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Maternal and Child Welfare in England and Wales Between the  
Wars: A Comparative Regional Study

Elizabeth Peretz

Ph.D 1992

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**MATERNAL AND CHILD WELFARE IN ENGLAND AND WALES BETWEEN THE  
WARS: A COMPARATIVE REGIONAL STUDY**

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**Ph. D. (submitted in partial fulfilment of the requirements  
for this degree)**

**November 1992**

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## Abstract

### Maternal and Child Welfare in England and Wales Between the Wars: A Comparative Regional Study.

Elizabeth Peretz.

This study explores the factors which shaped the local maternal and child welfare services of the inter-war period. It draws on research from local authority minute books, local newspapers, and from mothers themselves. It shows the strong influences exerted by the complex interplay of geographical, economic, political and cultural factors in determining the shape of services in the four very different localities studied here. The services were very different in the different localities, in two of the four areas expensive for the mothers, offering little practical medical or material help, and relying heavily on voluntary effort to meet government targets of every scheme being as self-sufficient as possible. Although it is shown that those indices of maternal and infant health, the infant and maternal mortality rates, fell in all four areas studied, the precise connection between educating the mothers and better perinatal and infant health remains to be established.

## Acknowledgments

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Much of the thesis has already been published as essays and articles. These have formed the basis of the following chapters:

Chapter One is based on Elizabeth Peretz, 'Regional variation in maternal and child welfare Between the wars: Merthyr Tydfil, Oxfordshire and Tottenham' in Philip Swan and David Foster, (eds), Essays in Regional and Local History, Beverley, 1992.

Chapter Two is an expanded version of Elizabeth Peretz, 'Infant welfare in inter-war Oxford', in Richard Whiting, (ed.), Oxford and its People, Manchester, forthcoming.

Chapter Three is an expanded version of Elizabeth Peretz, 'A maternity service for England and Wales: Local Authority maternity care in the inter-war period in Oxfordshire and Tottenham', in Jo Garcia, Robert Kilpatrick and Martin Richards, (eds), The Politics of Maternity Care, Oxford, 1990.

Chapter Five borrows half of its material from Elizabeth Peretz, 'The professionalisation of childcare', Oral History Journal, Vol 17, No 1, Spring 1989.

Chapter Six is an amended version of Elizabeth Peretz, 'The costs of modern motherhood to low income families in inter-war Britain', in Valerie Fildes, Lara Marks and Hilary Marland, (eds), Women and Children First: International Maternal and Infant Welfare, 1870-1945, London, 1992.

The Tables in Chapters One and Six are reproduced from the original versions above.

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## ABBREVIATIONS

Lewis, Politics of Motherhood - Jane Lewis, The Politics of Motherhood, London, 1980

MCW Committee Minutes - Maternity and Child Welfare Committee Minutes

MOH A/R - Medical Officer of Health Annual Report

NSPCC - National Society for the Prevention of Cruelty to Children

Our Towns - Our Towns: A Close-Up, Women's Group on Public Welfare, with a preface by Margaret Bondfield, London, 1943, 4th impression 1943

PH Committee Minutes - Public Health Committee Minutes

PRO - Public Record Office  
Social Services in Oxford - A Survey of the Social Services in the Oxford District, Barnett House Survey Committee, 2 Vols, London, 1938, 1940



## INTRODUCTION

The history of public health and social welfare in the inter-war years in England and Wales is the history of public campaigns and enabling legislation. Trends and patterns were shaped by the interplay of national and local forces, leading to what Roger Lee terms the 'uneven zenith' of the power of local authorities in the 1930s (1).

The Maternity and Child Welfare Act of 1918, with which this thesis starts, was a permissive piece of legislation. It was mainly a list of items which could attract government grants of up to 50%. The only statutory responsibility the Act gave to local authorities concerned committee duties and membership; one committee had to take on maternal and child welfare matters as a discrete set of responsibilities, and that committee had to contain at least two women as co-opted or elected members.

The three main areas of maternity and child welfare I discuss below are provision for infants and babies, particularly infant welfare centres; provision for mothers, from birth control to post-natal care; and provision for two to five year olds in nurseries or elsewhere. I look separately at the staff who ran or funded these services, and the mothers who used them, with particular reference to costs and charging. The Ministry and its Maternity and Child Welfare Department laid down some prescriptions regarding the shape of maternity services, and services for infants. In these areas of provision there are some local differences but also significant similarities. There was little attempt from Whitehall either to promote or standardise provision for two to five year olds, which makes local initiatives particularly interesting to study.

I have chosen the localities for their contrasts, and also for the availability of their records. Oxford City is a mine of information, almost obsessive in its record keeping on the voluntary, the personal, and the local authority side. Also, having an unusually stable middle-class population, there were many people still alive to interview about their experiences as volunteers, staff or mothers in the 1930s. Oxford was prosperous, expanding, with a stable and vocal public-spirited middle class. Merthyr Tydfil, on the other hand, suffered chronic unemployment, drastic population loss, and the erosion of middle-class philanthropy. It was a Labour dominated County borough, suspicious of the 'New Motherhood' and devoted to its own working-class wives and mothers. Geographically, Oxford and Merthyr are in marked contrast. Merthyr spreads over interlocking steep sided valleys, whereas Oxford was built on a flood plain. Tottenham is an interesting, more metropolitan area, compact, proud of being a 'leading edge' in the provision of services for mothers and children; in politics, more sedately Labour (Co-operative Labour) than Merthyr. Oxfordshire, by contrast with all these three, was the epitome of an old fashioned English county, where gentry owned whole villages and dominated county affairs, while agricultural labourers suffered poor wages and substandard housing. All four local authorities were different in status. Merthyr Tydfil was a County Borough created at the turn of the century within the County of Glamorgan from a cluster of villages. It operated apart from the County, having its own policies and its own budget. Tottenham was an Urban District Council for most of the inter-war period, without total autonomy. Some services were provided under Middlesex policies and budgets. Oxfordshire County Council had within it three urban district councils with varying levels of independence, in addition to Oxford which, like Merthyr Tydfil, was a totally independent County Borough. All these boroughs attracted social researchers in the

inter-war years. Oxfordshire was chosen in a study on infant mortality to represent a rural county with particularly low infant mortality rates, published by the League of Nations in 1931 and also as an occasional paper by the Ministry of Health; Merthyr Tydfil featured in a Ministry of Health study on the causes of maternal mortality, as a borough with particularly high rates; Oxford is the centre of a study on the growth of social services in a region experiencing industrial expansion at a time of industrial crisis elsewhere; and Tottenham attracted interest as a centre of excellence in public welfare provision. (2)

At the time, there was controversy about the efficacy of maternity and child welfare work. In 1938 an editorial in the Medical Officer talked of the pessimistic and optimistic views on the movement;

The pessimistic view is that these improvements are the minimum that must have happened, that the rising tide of progress and prosperity dragged them up in its train, and that the child welfare movement has had little say in their achievement. The optimistic view is that these improvements in child nurture are far in advance of general progress, that they are the best that could have been obtained with existing knowledge, and that maternity and child welfare work is mainly responsible for their satisfactory position. The truth lies between these extremes. (3)

The detailed local studies here suggest a position nearer the pessimistic than the optimistic view, although it is likely that clinic attendances and visits from health visitors did something to change upbringing patterns. What emerges from the studies is a complex picture; mothers themselves perceived little of the 'help' they were offered in that light; services were formed through a complex

interplay of geographic, cultural, economic and personal factors, little influenced by central government or Ministry of Health memoranda. However, looked at as it were from underneath, from the local perspective, new historical strands emerge. These include the continuity of 'church visiting' of the poor in the growing infant welfare movement; the triumph of home midwifery in the short lived 'National Maternity Service'; the steep costs to the individual of modern motherhood and the national bodies and industries that were developing in its wake; the 'colonisation' of the infant welfare movement by liberal and conservative women looking for a 'sphere of usefulness' outside home, but not at work. The studies show, too, how little like a State service an aggregate of these local services is; each had its own philosophy, its own shaping forces, its own mixture of voluntary and statutory provision which bore little relation to the next authority's; the Ministry remained deliberately an enabling rather than a shaping authority throughout, although officials tried hard to stop schemes that had no hope of being self-sufficient or that moved from the preventive health front to a curative or direct aid giving one.

This is in many ways only a beginning. Four areas are not enough to capture the scope of regional variation in Britain. With larger numbers of localities, statistics which are too small and ambiguous to use here in detail could be worked on. Historical geographers Jane Mark-Lawson, and Naomi Williams, and social geographer Roger Lee are currently working on other localities in this field, as is the historian Lara Marks. My work sits alongside that of these researchers. It also explores the local detail of historians of national health and social welfare: Jane Lewis and Charles Webster. On the one hand, it traces the reasons for the particular shapes which local maternal and child welfare provision took; on the other, it explores any



connections between this provision and the changing patterns of child health as indicated through rates for infant mortality.

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## CHAPTER ONE

### VARIATION IN MATERNITY AND CHILD WELFARE BETWEEN THE WARS: A COMPARISON OF MERTHYR TYDFIL, OXFORDSHIRE, TOTTENHAM, AND OXFORD.

Defining and redefining problems is part of a historical researcher's stock-in-trade. Some definitions seem particularly resistant to change. One such definition is that attached to origins of the welfare state in Britain; arguments for a peaceful revolution, in which voluntary activity gradually made way for the state machinery, obstinately persist. The autonomous workings of pre-war local government are given little attention; local authorities are seen as simple agents of the state. Voluntary bodies are complimented on their innovations, and then assigned to the wings as state actors take centre stage. (1)

Maternity and child welfare services have played a key role in this analysis; they have been described as some of the most advanced or complex of the inter-war state welfare services. Their history has been used to argue that state welfare services can develop and prosper without the framework of a 'welfare state'. This argument has given ammunition to those in the 1980s and 90s who seek to dismantle the British welfare state. (2)

Some researchers have challenged the view that there were effective public health and welfare services in the inter-war period. Charles Webster, in his first volume of the official history of the British National Health Service, throws doubt both on the completeness of the Welfare State which came into being in 1948, and on the growth of a national state welfare service in the years after World War

I.(3) He has argued elsewhere that welfare systems could only be as good as the localities administering them could afford, that little help came from Westminster despite government rhetoric, and that depressed areas therefore could not provide necessary health and welfare measures for their inhabitants.(4) Lewis and Macnicol have argued that the state family welfare system of the interwar period was inadequate for the existing needs of those with low incomes; they suggest that state welfare machinery, at a governmental level, was inhibited by employers' opposition to a minimum wage, professional opposition from the medical lobby, and a persistent distrust of intervention in the family amongst those in power coupled with a belief in self-help.(5)

These authors have gone a long way to shake the myth of a steady progress to the welfare state, and the effectiveness of inter-war public welfare services. However, it has been left to other recent researchers from the field of geography to look at whether the inter-war services could really be termed 'state' services with the homogeneity and central planning this suggests. These writers have looked at central-local government relations in the inter-war period, and have pointed to the vital role played by local authorities and local rates in 'state' health and welfare services.(6) Described from this geographical perspective, the inter-war relations between central and local government seem like those between a supervising and aiding authority, and a group of loosely federated towns and counties. Local government made its own decisions about a wide range of services including welfare and housing; in these matters national legislation was permissive, and the Ministry of Health was only a grant giving and advisory body. Using this perspective, which distances local authority initiatives from national ones, I would argue that a number of local histories of inter-war welfare need to be undertaken to examine central-local relations, local

circumstance, connections between the voluntary and statutory sectors on the ground, local need and local service. What needs examining is not, as was thought, the early days of a state service and its inexorable growth, so much as the transition from diverse local authority services, and their relations with the voluntary sector and the central government, to a more cohesive central system with its own voluntary connections.

What follows, then, is a description of maternal and child welfare, seen at the time and subsequently as one of the best developed 'state' services, in four contrasting local authorities in inter-war Britain. Relations with the Ministry of Health, connections between the statutory, voluntary, and private sectors, local circumstance and need, are all examined. Although the conclusions rest on only four geographical areas and their relations with central government, they go one more step towards illuminating the reality of 'state' welfare between the wars, and the origins of the welfare state.

National government was actively involved in debating and enacting policy connected with the health and welfare of mothers and infants from at least the turn of the century. The most important acts of parliament in this field are usually taken to be the Midwives Acts of 1902 and 1936, the Notification of Births Acts of 1907 and 1915, and the Maternal and Child Welfare Act of 1918. (See Appendix 2) In chronological order, these established a standard of practice and training for midwifery with a national register of midwives, a mechanism for officially notifying all births within 36 hours of their occurrence (the permissive Act of 1907 was made statutory in 1915), a mechanism for any group to obtain grants for work with mothers and children and a committee in every local authority to take responsibility for maternity and child welfare with at least two female



members (1918), and a national midwifery service mounted and supervised by local authorities (1936). There were other significant enactments; the formation of a Ministry of Health with a Department of Maternity and Child Welfare in 1919, the provision whereby general practitioners called in by midwives in an emergency were to be paid in the first instance by the local authority (1918), the Nursing Home Registration Act of 1927, and the 1929 Local Government Act which brought all the Boards of Guardians' responsibilities under the local authorities, and changed the procedure for obtaining government grants.

This legislation was supervisory and administrative on the one hand, and on the other enabling, or permissive. Only a skeleton staff was mandatory to carry out the supervisory functions; local authorities and voluntary societies who wanted to provide services, and could pay for at least half of their cost from rates and fees, could apply to the Ministry for a 50% grant before 1929, and after 1929 persuade the local council to release a similar proportion of the block grant received from the Ministry. If the services (infant welfare clinics, ante-natal post-natal and gynaecological clinics, maternity hospitals, nurseries) were not provided, there was little the government could do about it.

The Maternity and Child Welfare Department at the Ministry of Health dealt with grant applications from local authorities and voluntary organisations, produced memoranda for distribution to these agencies, and sent supervisors to assess and advise in localities. The department dealt with the over 200 local authorities of England and Wales and probably as many voluntary associations. This gave the Ministry a certain limited power in overall policy, although even this was further limited by Treasury dictates. But they were mainly confined to dealing with requests, and

trying to respond to them in years of economic stringency. Their ability to generate new services where local authorities or voluntary groups were unwilling was very limited. Where this was felt necessary, memoranda were sent out - this happened over provision for toddlers in the late 1920s, and birth control in the early 1930s. Those authorities who did nothing were, on occasion, visited by a Ministry official for report and discussion; if a local authority made no effort to respond to Ministry recommendations they faced the threat of difficulties over the following year's Ministry grant. But teeth were seldom bared; after all, services absent meant money saved. Following the Local Government Act of 1929, the Ministry set up Public Health Surveys as a more formal method of monitoring and recommendation to local authorities. These recommendations did begin to have some effect, particularly as larger grants and more capital projects began to be centrally aided as money became more freely available in the later 1930s. But even then, schemes presented to the Ministry could be made to seem more comprehensive than they were. (7)

While local rates and local charitable effort determined the scale of public health and welfare services, those people who were the local policy makers throughout the nation were those who fixed the rates, controlled the local councils who determined how these rates should be spent, and provided, collected and administered the charitable donations for health and welfare bodies like voluntary hospitals, nursing associations, or the infant welfare associations. These were usually the financially powerful of an area, the landowners, or works owners and their wives, who were in turn influenced by local traditions, cultural patterns, and (where these were strong) working-class organisations, as well as the more practical considerations of geography and level of prosperity. Gillian Rose has exposed these

patterns of power in relation to local government in Poplar, and Jane Mark-Lawson in two towns in the North-West. (8)-

Below is a brief outline of the services available to mothers and infants living in the four local authorities to be compared in 1937, the year the Midwives' Act came into full operation. The comparison reveals discrepancies in provision which are then discussed in context. The concluding section draws out some underlying common themes.

#### Maternal and Child Welfare Services in 1937 (See tables 1-2)

##### Tottenham

Of all the areas discussed here, Tottenham provided the fullest and most accessible service for its mothers and infants in 1937. (9) A mother in financial need, whether on Unemployment Benefit or simply in a low income household, could obtain the following help from the Borough's Public Health Department. On suspecting pregnancy, she could walk to her nearest ante-natal clinic. With a choice of three in the Borough open three afternoons and one morning a week, all staffed by an obstetric specialist and health visitors, and all within two miles of the furthest citizen, mothers had choice as well as availability. The visit was free to all comers. At most, a mother might be asked a penny for a cup of tea, or encouraged to join a thrift club. Over 41% of all expectant mothers in Tottenham attended ante-natal clinics in 1937. (10) If all seemed straightforward to the obstetrician who examined her, she could then book a midwife at the Town Hall, during office hours; the Town Hall was no more than a mile from any part of the Borough. In April 1937, the Council agreed that midwifery charges would be 42s. a case for first children, 31s.6d. for second and later children, slightly more than the 30s. maternity benefit payable to those mothers covered under National Health Insurance through their own or their husband's work. A



generous 'scale of eligibility' was offered for mothers on low incomes. Those women whose cases were not thought to be straightforward, either because of poor home facilities or because of obstetric problems, were advised to go into hospital. Some Tottenham mothers elected to go into hospital themselves. Charges were around 42s. for a ten day stay, so there was little financial incentive to stay at home, particularly since those in the low income bracket were eligible for free hospital treatment and free home helps to look after their families in their absence. It was reported to the Maternity and Child Welfare Committee in January that an average of around 40% of Tottenham mothers were delivered in the North Middlesex Hospital or the Mothers' Hospital in Clapton in the three years 1934-6. If an emergency developed during the confinement, whether at home with a domiciliary midwife, or in hospital, an obstetrician was called in, or a general practitioner, whose fees were paid in the first instance by the Council. The Council expected little to be recovered from the families themselves; in February 1937 it was estimated that only £20 of the £120 allowed for under this heading would be recovered from patients. (General practitioners' and consultants' fees for these cases might be anything from £1.1s.0d. upwards depending on the case.) (11)

Post-natal clinics were held at the ante-natal clinics and a gynaecological clinic was attended by well over one hundred women with a wide variety of problems, the most common being 'menstrual irregularities'. Convalescent treatment for mothers was available in the Borough and in Hampshire at Hayling Island; here, as with the other services, there was a generous scale of eligibility. This was a full service in comparison with the rest of England and Wales for 1937, but even so Dr Kirkhope, the Medical Officer of Health, wrote in his Annual Report of 1937: 'Complete as these services appear to be, there are still ways in which they can be

further improved.'

Infants fared as well as their mothers. A full home visiting service by health visitors ensured supervision of the majority of infants from the midwife's last visit to school entry at five. Infant welfare centres, well equipped and situated in their own Council premises were open almost every morning and afternoon of the week in all corners of the Borough. During 1937, a purpose built Council health clinic was opened for school, maternal, and child preventive health. This building was a matter for civic pride, with its modern architecture, splendid equipment, trees and fountains. All clinics were staffed with paediatric staff, health visitors and volunteers who gave advice on infant care, clothes and feeding. Mothers' committees played a prominent part in these clinics. The health visitor could authorise a mother on low income to have free treatment for herself or her infant at the dentist, the minor ailment clinic, the ear nose and throat clinic, the orthopaedic clinic, the artificial sunlight clinic, the ophthalmology clinic, or the local X-ray department. Free butter, Virol (a proprietary malt and oil preparation), milk (at a generous 1½ pints a day), cod liver oil and malt were all available to such mothers. Working mothers could use the Council's daily creche in the south of the Borough, where the fees were the lowest and proportion of trained staff the highest compared with those of neighbouring Councils. The list of good facilities continues; Vale Road Nursery School, another cause for civic pride, built on model lines, had just been opened in the north of the Borough, for a small number of two to five year olds. Infants needing hospital or convalescent treatment could obtain this free on a generous scale of eligibility. (This was paid for partly by the local Invalid Children's Aid Association and partly by the Council.)

The take up of these services (see table 1.1) was enhanced by widely publicised annual Council public health weeks, when all the institutions above had open days, and posters, films, baby shows, and school competitions marked the occasion.

#### Merthyr Tydfil

Merthyr Tydfil's 1937 service was in marked contrast to that in Tottenham. Here a mother had no easy way of finding her Council midwife; she might have to travel four or five miles by bus to the local ante-natal clinic, only to find that this makeshift affair in a local chapel or club would not be open for another ten days. If the mother was checked - in this case by the public health Assistant Medical Officer of Health for Maternity and Child Welfare - and thought to be in need of hospital treatment, she might be referred to the maternity wing of the local public assistance infirmary, where she would be kept under the intermittent inspection of Professor Strachan from Cardiff, an obstetrician who was paid to make the 20 mile journey for Merthyr's obstetric abnormalities. Merthyr's Domiciliary Midwifery Service was in place in 1937, with all the midwives employed directly by the Council. Although this was a paying service, in practice the many families on Unemployment Rates received free midwifery; after much Council debate, it was agreed that families of three persons earning 30s. or less a week after deduction of rent should get midwifery free, and so should families of five persons earning 50s. or less. (12) Hospital costs were normally 42s., compared with the home midwifery charge of 25s. After emergencies, however, mothers might be faced with steep charges for doctors or specialists which they had to pay back to the Council; one such woman was bound in court to pay off over £20 in instalments of 2s. per week. (see Chapter 6)

A rather thinly spread service of health visitors covered the precipitous terrain of the neighbourhood to provide home visits to mothers; often an infant would only be visited once before entering school. However, mothers could get cod liver oil and milk free at the infant welfare clinics until a child's first birthday, on production of an unemployment benefit card. Informants have remembered this distribution as the main, if not the only, function of the clinics.

This service was not easy to get to, and neither were the clinics for artificial sunlight treatment, orthopaedic treatment, or minor ailments held in the centre of the Borough. Bus fares were occasionally paid, as were the train fares for poliomyelitis sufferers going for treatment to Cardiff. There was one nursery school, for twenty children, for which mothers had to pay 1s. a week; this was poorly placed for much of the Borough, several miles distant at Dowlais, and was almost totally maintained by voluntary donations. (13)

### Oxfordshire

In Oxfordshire, the poor mother had an even less attractive deal in 1937 than her counterpart in Merthyr Tydfil. No ante-natal clinics existed. A mother could ask a general practitioner to examine her twice during her pregnancy for nothing, but for those mothers with no regular habit of paying for consulting a doctor this would have been hard to arrange. The 'Council' midwife was in reality employed by the local district nursing association who worked under loose contract for the local authority. These midwives were mainly District Nurse-Midwives, with only an 18 months to 2 years training rather than the State Registered Nurse's three years. A mother paid 25s. for a confinement provided she contributed 2d. a week insurance money for the local nursing association. If not, she paid 30s. (14) Only one in ten deliveries took place in hospital. For mothers who



preferred this route, and for those who were referred, hospital could make a large hole in the family budget (see chapter 6). Mothers who were to be confined in hospital had to attend ante-natal sessions in Oxford, which might easily have involved both bus fares and child care, and special clothes and nightclothes were expected for the fortnight's hospital stay. The Council paid few bills, and reclaimed what it could. The only real help given was in the payment of doctors to attend in emergencies at home; less than a third of this money was ever recovered in Oxfordshire, as elsewhere, despite attempts to improve collection. After the baby was born, a health visitor - a busy woman with five separate responsibilities and a patch of 70 square miles to cover, often without a car - paid at least one visit. A mother was then invited to a makeshift Infant Clinic open once a fortnight for a few hours, where she could obtain expert advice from a visiting general practitioner or the health visitor. She also risked scrutiny by the village elite, from the church or manor, who came to the clinics to do their voluntary work, make tea or sell cost price dried milk or Virol. Free milk could be given, though it seldom was. Hospital or minor ailment treatment could also be paid for by the Council, as could home helps, but only a handful of families were helped in these ways each year.

### Oxford

Oxford County Borough was in a position to provide comprehensive local state services. In marked contrast to Merthyr Tydfil, Oxford was a rapidly expanding town with flourishing industry based around car manufacture. In the event, their provision was good, but not as broad or available and accessible to poor mothers as Tottenham. In 1937 there were five ante-natal clinics attended by one third of that year's expectant mothers (446 out of 1343).<sup>(15)</sup> Hospital maternity provision was in two places; the Poor Law Infirmary in the Cowley Road, where a handful



of poor mothers were confined, and the Radcliffe Maternity Home, with forty four beds, seven of which were for private patients, that served Oxford and Oxfordshire. Costs here were £3.6s.7d. per week. Most mothers were advised to spend two weeks in hospital. Post-natal provision was in the ante-natal clinics, and in 1937 only thirty-nine women attended, a very small proportion of the 1343 births. Oxford Council maintained one birth-control clinic open to the ill and the necessitous, with twenty-eight cases in 1937, and the voluntary Oxford Family Welfare Association provided a clinic where in practice 'contraceptive advice is given to every married man or woman who desires it' for 1s., and 'appliances are provided at special clinic prices'. There were 151 new patients in 1937, many of whom came from outside Oxford. There were thirteen infant welfare centres, for the most part open only once a week for a couple of hours, with health visitor, volunteers, and the Assistant Medical Officer of Health for Maternity and Child Welfare in attendance. There were no day nurseries, no free meals, no special minor ailments clinics (although the Radcliffe Infirmary held a weekly Sick Baby Clinic, and toddlers could use the School Minor Ailments Clinic), no artificial sunlight or orthopaedic clinic, and two Saturday morning dental clinics open to expectant mothers and infants under school age. In all, 117 mothers and 116 children used this service in 1937. Milk and vitamins were provided through the clinics, free or at cost price.

### Regional Differences

Why were there such differences in service as those described above? Was it something about the localities themselves and their citizens, or to do with central/local relations between local Public Health Departments and the Ministry of Health? Who instigated the growth that took place in each locality's maternity and child welfare service? Below, these questions are examined in turn, in each locality, before concluding with some speculations about the wider picture of maternity and child welfare between the wars.

There was a reservoir of health expertise in the London area which benefited Public Health Departments like Tottenham. The latter employed part-time specialist obstetricians, gynaecologists, and paediatricians who worked in the London teaching hospitals; they had access to specialist institutions - including maternity hospitals, which they could and did buy into; they could attract professionals who were well trained, and took advantage of further training schemes in London. Tottenham's voluntary hospital kept a low profile in the maternal and child welfare field, in contrast to several East End hospitals. (16) The local newspapers heralded health weeks, new housing, institutions, and public parks with great pride. Children were the symbol of Tottenham's future; the Council promoted special children's services, and the press devoted space to reporting and photographing this.

The blueprint of services outlined in the Maternity and Child Welfare Act of 1918 by the Local Government Board, and grant aided by the Ministry of Health from its inception in 1919, closely resembled the service mounted by Tottenham Public Health Department under Dr David Kirkhope, a fiery Scots Barrister, chairman of his local NALGO branch, and continued from 1937 by his successor Dr Hamilton Hogben

(Lancelot Hogben's brother). These were both men of vision, empire builders, full of the rhetoric of preventive health services and dedicated to their provision. They worked closely, and amicably, with their councillors and with their staff. They were fortunate in Mrs Kent Parsons, Superintendent Health Visitor, who remained in office throughout the inter-war period, and was active in national affairs in the National Babyweek Council and the Health Visitors' Association, and with the planners at the Ministry of Health, but had more than one collision with the financial part of the Ministry which wished to curb their spending and reduce their scales of eligibility. (17)

Voluntary associations which did operate in Tottenham did so to enhance the Council's service, or stop gaps in that service.

It was very different in the other three areas. Merthyr was overwhelmed with first acute and then chronic unemployment problems. The population changed in age structure as many young people left in search of employment. Births fell. (see table 1.2) Although Merthyr had become a County Borough in 1912 it was geographically more like a string of villages perched on the precipitous sides of two high mountain valleys. Ordinary environmental health services were difficult and expensive to provide. A special reservoir was constructed by Merthyr Tydfil at a time of earlier industrial expansion, which put the Council badly in debt from the early 20s. (18) By this time the iron works at Cyfartha had closed, and the population diminished. Much of the water from this reservoir, Taf Echan, was superfluous, but it still had to be paid for. Drainage, subsidence, streets, street lighting, and all these services were expensive. The Borough covered sixteen square miles, spread out in long fingers up the valleys. Glamorgan, the surrounding County Council, took on none of the public duties of Merthyr; as a County Borough, Merthyr had

responsibility for all its services. This was in contrast to the more prosperous Tottenham, first an Urban and then a Metropolitan Borough, which had many duties taken off its hands by the County of Middlesex. After 1929 Merthyr also took on responsibility for the Poor Law administration within its boundaries; until then this function had been shared by several towns and villages in the area. Provision of out relief for the high number of chronic unemployed was very expensive; between 1931 and 1936 the average annual sum paid out was £581,004.13.4d. The people of Merthyr faced a difficult task in providing public services at all; they faced this problem because of economics and geography, not because of trying to provide a full service. Widespread unemployment faced them with yet more difficulties. Rates provided a small revenue because of empty houses and non payment through bankruptcy and unemployment to the point where the rates in the pound had to be set at 29s.6d. just to cover the following year's immediate expenses. Oxford and Oxfordshire kept their rates to around 7s. in the pound throughout the period, thus keeping rates paid by individuals at a much lower level than in Merthyr. Charles Webster provides a full discussion of this point.(19)

The political complexion of the Borough Council put them in opposition to many of the local magnates, which only served to worsen matters. The Council, with a Labour majority from the early 1920s onwards, faced hostility from the local ratepayers to the extent that a public assessor was employed by the Government in 1935 with a view to disbanding the Borough altogether. There had been three deputations of angry ratepayers (the anti-Labour group) to Whitehall since the end of World War I. It is instructive that at the end of a year the assessor, Sir John Rowland, had nothing but admiration for the Council.(20) Miners and steel workers were the dominant groups in Merthyr; the Labour Party was dominated by miners. Their culture was a male one at work



and in public affairs, and in this aspect of their belief they were conservative, and so were their wives, who were proud of their housekeeping and large families. This predominantly working-class district had its landowning and works owning minority, who continued to exercise power through the district; their views dominated the newspaper, the trades, and the professions. They had wider influence, too, in Cardiff and London.

The voluntary movement, led by the iron and coal owners and their wives, was small but persistent in Merthyr Tydfil. Voluntary work represented a channel for civic pride and citizenship in contrast to the Labour demands for jobs, fair wages, and proper unemployment pay. The maternal and child welfare movement occupied a very particular position in Merthyr as a result of these particular circumstances. The most outspoken political champions of the system were liberal professional women who used the needs of women and children as a political platform to oppose the Labour call for proper unemployment pay and the end of the means test. One such towering female figure was Mrs M A Edmunds who came into politics in the Edwardian period as a School Board member dedicated to teaching housekeeping in schools; she was opposed by the working class councillors who felt their wives and daughters were good enough housekeepers already. (see Chapter 5)(21) People such as Mrs Edmunds saw Council maternity and child welfare provision as an extension of existing voluntary provision in the area, another way to claim government grants or obtain rate support for targeted self-help exercises. Similar views were championed in Oxford and Oxfordshire. However, in Merthyr, the middle-class professional citizens were not in control of the Council; their influence rested in encouraging national voluntary bodies, like the Save the Children Fund, Pearson's Fresh Air Fund, and the National Birthday Trust Fund to help

provide holidays, nursery schooling, boots, Christmas treats, and patent strengthening foods to Merthyr.

The Council maternity and child welfare service itself was used by the Labour majority largely as a way to get central government grants to supplement food for the unemployed with young families; milk was consistently the largest item on the Maternity and Child Welfare budget, and the recipients were agreed every week by a committee of one or two councillors, not exclusively Labour. (22) The other parts of the maternity and child welfare service such as those offered to mothers in Tottenham were not ignored, but they were difficult to provide economically in such inhospitable terrain. The concerns Medical Officers of Health brought to the Council meetings were environmental, often to do with housing which was very poor in the Borough. Dr Stephens, himself the son of a local doctor in Merthyr, took over as Medical Officer of Health from Dr Duncan in 1934; he had only obtained his MOH qualification after a year as Acting MOH in the Borough. The Council unusually employed an Assistant Medical Officer of Health as Superintendent of Midwives and Health Visitors; during the period, three energetic women doctors, Dr Eppynt Philips followed by Dr Griffiths and Dr Esther P Jones, organised Maternity and Child Welfare work in Merthyr. Dr Jones concerned herself with the polio outbreak and with orthopaedics, and also with the effect of goitre on local mothers. Dealing with infectious outbreaks, the effects of malnutrition, and the effects on health of long term unemployment and poverty left little room for the niceties of corrective and preventive infant and maternal services.

Oxfordshire was a large, prosperous county in the heartland of England. It covered a large area (736 square miles) of scattered villages and small towns, with considerable floodland and few major roads or railways. Agriculture was

on the decline. Between 1912 and 1936 the proportion of the working population in this field fell from a third to a quarter. The car works in Cowley, which grew dramatically in the inter-war period, recruited from the countryside. The result was that the county's population continued to rise, unlike that in many rural areas. Poverty, in this situation, was very uneven; agriculture was particularly poorly paid in Oxfordshire, while Morris's car works paid well provided the market was good, but frequently put employees on short time or suspended employment.

Oxfordshire had a substantial landowning class; in 1937-8 fifty of the sixty-six villages surrounding Oxford were one quarter owned, and twenty of the fifty entirely owned, by one landlord.(23) It was this landowning class that dominated the County Council throughout the inter-war period. Three quarters of the sixty members were landowners, the rest mainly professional men from the small towns. It remained Conservative throughout. There were only at most four women on the Council. The voluntary associations of the County grew in strength in the inter-war years, particularly the Oxfordshire Nursing Association, the Oxfordshire Federation of Women's Institutes, and the Oxfordshire Rural Community Council. The committees of these associations were dominated by the landowning class; Lady Jersey, the Viscountess Harcourt, Mrs Morrell of Headington Hall, Miss Ashurst of Waterstock, Lady Parker, Lady Mason.(34) Connections between the voluntary associations and the Council were strong; Miss Ashurst was for many years chairman of the County Council and at the same time Chairman of the Oxfordshire Rural Community Council.(see Chapter 6) Keeping the rates down was seen as a priority here as in other Conservative areas. They were remarkably successful in this; where on average British local authorities owed 7d. a head for public service loans to the lending banks in 1937, Oxfordshire only owed 4d. a head. The Public Health Department of the Council was



small; it comprised a Medical Officer of Health who was also the School Medical Officer, and a Supervisor of Midwives and Health Visitors, seven health visitors (rising to fourteen by 1939), and one midwife in Henley. The Medical Officer of Health Dr Coles retired in 1932 to be succeeded by Dr Jennings, who did research on tuberculosis. Miss Florence Pearce, Superintendent of Midwives and Health Visitors, who arranged most of the maternal and child welfare work in the county, retired in 1936 after thirty years to be succeeded by Miss Mary Owen. (see Chapter 6) (25) Midwifery was done under contract by the Oxfordshire Nursing Federation, which was in comparison a much more powerful public body than the Council's Public Health Department, employing sixty-three District Nurse-Midwives, most of whom had been trained under their charge at the Plaistow Maternity Charity and Nursing Home. Mrs Morrell of the Oxfordshire Nursing Federation and the county elite was a much stronger agent of change here in maternity and child welfare than the officials. (26)

Oxford's geography and topography undoubtedly played a part in forming its political and economic climate. It was built on a small area of raised ground set in a wide flood plain on the Upper Thames. By World War I it had overspilled its old limits to spread along the causeways to the surrounding hills, and sprawled out in a star shape. The open spaces this created were difficult to build on or to farm, and therefore of little value to their owners (many of them Oxford Colleges) who were content for them to become playing fields or allotments. By World War II much of the higher land surrounding the flood plain had been built over by public and private enterprise. Although it was recognised and widely publicised that this was for the health of residents since it would remove them from the unhealthy damp of the flood plain, it had the added attraction for developers of being easier building terrain; the causeway ribbon developments had only been possible with extensive



rubble infill, and had still been subject to regular flooding. The Public Housing estates in Cowley, Headington and Rosehill certainly provided the poor of inter-war Oxford with better housing, but it was more expensive and entailed high transport costs to and from work.

Before World War I the economy of Oxford revolved around three main functions; those of a Cathedral town, a University town, and a county market town. There was little industry. Most work was connected with servicing and distribution. The University was the main employer. The large number of professional households in the town needed housing, shops, and servants. People living in the surrounding county districts of Oxfordshire and Berkshire needed Oxford for specialist services - solicitors, specialist medical practitioners, private schools, outfitters. (27) During the 1920s this changed dramatically. Oxford became an industrial centre, rapidly growing in size and prosperity. (28) The combined action of migration into Oxford to supply Morris's car manufacturing workforce in Cowley, and the incorporation of Cowley and other 'suburbs' into Oxford County Borough after the 1929 Local Government Act, doubled Oxford's area and increased its population by a third between 1918 and 1937.

Oxford had a different age distribution from England and Wales as a whole; in 1931 there were 50% more twenty to twenty-four year olds (and considerably fewer children up to the age of four) than the average elsewhere. (29)

Social conditions in Oxford throughout this period were uneven. Although the effects of the depression are less marked here than elsewhere in England and Wales, there remain plenty of signs of poverty, in housing and unemployment. After World War I, employment was slow to pick up. The National Unemployed Workers Movement was

active in the town during 1920-23. Deputations were sent to the Council and to the Board of Guardians to press for relief and public work. (30)

Other such acrimonious struggles went on all over the country, as Wal Hannington relates in Unemployed Struggles in 1936. (31) At a demonstration in 1922, one NUWM speaker estimated Oxford's unemployed at 2,000, or just over one in ten amongst the population of working age. Things should have improved after 1923, with the growth of the car industry. However, the car industry employed young, fit, men; women were not employed. In fact very few women worked in Oxford in anything other than domestic employment, and of those who did, it was estimated only 12% were in the kind of employment that involved National Health Insurance contributions. (32) Morris's policy of not employing older men may well have affected the income of precisely those whose growing families depended on them. Being a Morris employee was not a secure position in itself; Morris coped with the market fluctuation in automobiles by putting people on short term work or laying them off temporarily, throwing family incomes into jeopardy. Although average unemployment remained around 1,000 in the inter-war years, actual numbers experiencing hardship may well have been greater. (33)

Overheads for families were high; transport has already been mentioned. Housing was scarce and expensive throughout the period. A collection of shacks and tents near the car works in Cowley was a permanent reminder of this fact. (34) The Oxford Times estimated that the number of homeless remained at around 2,000. Despite a rapid increase in new houses built after the late 1920s, the majority of housing available remained in private hands, out of the reach of many earners. (35)

Council provision for young families grew in Oxford in the context of a well established voluntary tradition. The

Oxford Health and Housing Association, described in Chapter 2 below, the National Society for the Prevention of Cruelty to Children, and the Oxford Police Aided Society for the Clothing of Poor Children moulded the Council's maternal and child welfare provision. They were all serviced by the same network of local elite. L R Phelps, Provost of Oriel, remained influential in civic life from the 1890s to the 1930s. He was Chair of the Charity Organisation Society (COS) and of the Board of Guardians. As Chair of the Board of Guardians, he championed the reduction of outrelief in the interest of targeting the deserving more accurately. It was a basic tenet of the COS to categorise the poor as deserving and undeserving, and to help only those thought to be capable ultimately of helping themselves. Although he was never himself on the Maternity and Child Welfare Subcommittee, he was on the Public Health Committee of which it was part. Like many of Oxford's elite, he had a national as well as a local position. He had been a fellow member of the 1909 Committee on the Poor Law with Sidney and Beatrice Webb. Many of the people in the network which dominated social welfare in Oxford were, like Phelps, connected with the University. An unusually large number were women, wives of academics who became powerful public figures in their own right. Mrs Prichard, with a first class honours degree, wife of H A Prichard the Professor of Moral Philosophy, was arguably the most influential figure in maternal and child welfare through these years.(36)

She was in the leadership of voluntary and Council committees throughout the 1920s and 1930s, an active member of the Education Committee, and a campaigner in the field of mental handicap. Her influence continued into the post-war period, when she remained in city politics, remembered for her stringency with the public purse as a Councillor visitor to children's homes.(37) Mrs Wells, wife of the Warden of Wadham, Mrs A L Smith, wife of the Master of Balliol, and

Mrs H A L Fisher all worked in the voluntary associations for mothers and children (see below, Chapter 2). They believed in educating mothers about modern childrearing methods, and being sparing about what was given free; they preferred funding from private purses by subscription to voluntary bodies to funding from raising the rates, and gave their own lives wholeheartedly to public service. Mrs H A L Fisher's inter-war years books on citizenship exemplify their beliefs. (38) The Medical Officer of Health for Oxford until 1931, Dr Ormerod, frequented the dining rooms of these households; according to Mrs Prichard's daughter, and Mrs Wells' son, he was often at evening prayers in their houses, and known as a friend of the family. Brian Harrison quotes the sentiment of this network which dominated Oxford's civic life:

there are, and for my part I fervently hope there always will be, endless things which we can manage ourselves, voluntarily, in ways that suit ourselves and the special needs of our locality. (39)

Although this group knew well enough the needs of the poorer mothers of Oxford - Mrs Smith wrote an impassioned letter to the Oxford Times in 1930 drawing attention to the dreadful housing conditions in the City, quoting a family with a baby and a toddler living and sleeping in one room - their beliefs led them to shy away from state provision of free service. (40)

#### Standardising factors in the shape of local services

Are there any general points to be made about how these services, which played such different parts in their locality's lives, were constructed? Could policy emanating from the Ministry be seen as formative?

The years between 1917 and 1921 saw a burst of enthusiasm nationally for maternal and child welfare. This reflected the overlap of the 'save the babies' fervour of the last



years of the war, and the 'home fit for heroes' fervour of the first years of peace. The voluntary movement which produced the National Babies' Weeks also pressed for government support for working class families, and even their housing. This Liberal supported period of expansion came to an abrupt end with retrenchment. However, its effects were nationwide. In Tottenham the Medical Officer of Health won the assent of his new Maternal and Child Welfare Committee to combine the existing voluntary and local authority provision into a completely overhauled council service in 1919-20. He won what grants he could from the Ministry of Health for the creche, cot centre, infant welfare centres, and staff, and approached the Carnegie Trust when the central government refused to give any more. The end of these years in Tottenham was marked by Dr Kirkhope's angry letters and deputations to Whitehall when the Ministry cut the grant for free milk for mothers and infants. (41)

In Merthyr there was little attempt to build a maternity and child welfare service in these early years; housing was seen as the most pressing need, and council effort went into council housing plans, which were thwarted by the Ministry. However, the cutting of the milk grant produced a letter of protest from the Council here as well. (42)

In Oxfordshire, very little milk had been distributed under the Milk Order of 1919, and no protest followed grant reduction. However, there was protest in 1922 when the Ministry threatened to withdraw the grant for the seven county midwives, employed in 1916 to plug the gaps in the voluntary association's network. The protest was resisted by the Conservative councillors. The Public Health maternity and child welfare service here, as we have seen remained almost skeletal. Baby Week in Oxford in 1917 was a triumph for the women of the Voluntary Association. A film

publicising infant welfare work was shown twice nightly to packed audiences in the City's two cinemas. The well known actress, Mrs Irving who took the principal part - of the Health Visitor - in the film was there in person, staying in Oxford with her brother, A.L.Smith, Master of Balliol. William Osler, then Regius Professor of Medicine at Oxford, addressed a crowd on the importance of getting married, having children, and living in a decent house. Oxford's short lived 'Citizens Association' (1917-1922) began here, campaigning for cleaner streets and better housing. It ended as the national enthusiasm for state intervention ended, with retrenchment(43). Oxford's response to the Milk Order of 1919 was to submit two schemes, one from the Public Health Committee and one from the voluntary association to the Ministry of Health, who chose the one suggested by the Medical Officer of Health. The scheme did allow families in need of free milk to obtain it, but put them through several hurdles on the way. The Medical Officer of Health or his official health visitors had to call to register the family first, and interview them. They were then issued with a card, to be produced retrospectively at the Town Hall Office with the milkman's receipt to reclaim the entitlement.(44) What family in that kind of need would have the money to pay in the first place? Or would have the time to visit the Town Hall?

When the Local Government Act was passed in 1929, all local authority services which until then had received backdated yearly 50% grants were allotted new block grants on a three year plan. One of the objects of this Act was to provide more uniformity of public service from local authorities. But it was flawed from the start. Despite a complicated scheme of calculations intended to improve grants to poorer authorities, the three year projections were mainly based on the local authority's past budgets. In Oxfordshire, Oxford and Merthyr this left little room for manoeuvre. Public

Health surveys were conducted from the Ministry of Health to encourage change; officials could always produce the threat that funds would be discontinued. Oxford, Oxfordshire and Merthyr all had more than one such survey; Tottenham apparently escaped without one, possibly because of its status as Urban or Metropolitan rather than County Borough.

Merthyr was engulfed in problems of unemployment and massive public assistance bills and produced very little change in the maternity and child welfare service in these middle inter-war years. The Ministry of Health carried out two separate surveys of maternity and child welfare provision (in 1929 and 1931) criticising the service, and as a result some changes were made to provide a hospital service for maternity cases and a little more health visiting. (45) However, as Esther Jones said herself in a Council meeting in 1936, infants in her care needed boots, not cod liver oil. But the Government would not provide grants for boots, so she had to make do with cod liver oil. (46) In Oxfordshire the 1929 Act produced no change at all except a slight drop in population with the extension of Oxford City boundaries. In Oxford 1929 produced the withering of the Voluntary Infant Welfare Association as a body, even if its personnel continued to serve as councillors on the Council. The Local Government Act ended the practice of voluntary bodies being directly funded from Whitehall; the money came via block grants to the Council. The peppercorn rent for the clinics was paid in future by the Council.

Oxfordshire, with a more meagre public service than either of the other areas looked at here, were only asked for minor adjustments after their public health surveys, despite damning comments on the laziness of the Medical Officer of Health. They were asked for an obstetrician, to call in emergencies, and for an increase in health visitors, an increase already being demanded by the county's public

health committee itself. The named obstetrician made no domiciliary visits in the first two years of his appointment. (The City of Oxford was upbraided for its lack of trained medical experts at the infant clinics and its lack of ante natal work; both these problems were rectified between 1930-1933, but it is not clear whether the changes were as a result of the Public Health Survey of 1930, or the retirement of Dr Ormerod as Medical Officer of Health, and the advent of Dr Williams.)

From 1937 onwards the country saw a general increase in capital investment in maternity and child welfare, and an extension of services. Plans for purpose built maternity and child welfare centres were put forward for two sites in Merthyr, and two in Tottenham. In each case the plans were generated with Council enthusiasm to consolidate school and infant health departments. Both authorities met opposition from the Ministry of Health over their plans, the proposed sites, and the costs (perceived as extravagant). Tottenham built two centres, one in 1937 and the other in 1940. Tottenham and Oxford also put forward plans successfully for purpose built nursery schools, both opened in the late thirties. Oxfordshire had no such plans for capital investment, and received no chiding on this head from the Ministry.

The 1936 Midwives Act bound local authorities to provide an adequate midwifery service for their population; this in aggregate was the basis of the acclaimed national Maternity Service (see Chapter 3). Tottenham employed as many midwives as they were allowed by central government; they asked voluntary associations to submit plans, according to Ministry directions, but only accepted contracting for a minority of the service in this way. Merthyr employed all its own council midwives; there was no nursing association with enough funds to help support a midwifery service.



Oxford decided that the government standard to measure how many midwives were necessary was too high, opted for the measure of eighty cases a year rather than seventy, and employed six municipal midwives to undertake all the midwifery for the City with four Nursing Association Midwives employed by the Radcliffe Infirmary Maternity Home. Significantly, Oxford also employed two almoners to collect the fees. Oxfordshire contracted out for all midwifery needs to the Oxfordshire Nursing Federation, except for one anomalous County midwife employed since 1917. Voluntary hospitals and private practitioners had contracts with the council to provide the rest of the referral services. This scheme, which relied so heavily on the voluntary sector, received the Ministry's approval rather more readily than that in Tottenham; the 'state' service represented in Oxfordshire was little more than a voluntary system under local authority supervision.

### Conclusions

What conclusions can be drawn from this initial comparative exercise? First, in the areas under discussion, maternity and child welfare followed a different pattern, occupied different places in the political agenda of public life, and formed such different services with such different champions that direct comparison is possible on only a superficial level. It is likely that more regional studies of services would produce some useful generalisations. Conservative counties may have mainly adopted the voluntary model. Labour enclaves with a male dominated workforce and working-class culture may have shied away from extensive preventive public health which apparently undermined their families' autonomy and questioned their values, and have encouraged instead workers' health insurance schemes for all ill health, and schemes for housing and education. Jane Mark-Lawson's contention that working-class communities with a substantial female workforce produced a full maternal and

child welfare service, with creches and hospital provision, may well be shown to be correct, although Tottenham is only a partial example of this. Central government did little to even out such fundamental differences between services.

The experiences of maternity and child welfare in these local authority areas reflects the dominant themes of the localities, and the relations of these local councils with the Ministry of Health. They do not reflect simple explanations for unevenness of service. A simple connection between the needs of the mothers and children themselves, as measured by mortality rates or by relative poverty, is not evident. The Ministry seem to have been reluctant spenders throughout in a service in which they encouraged the voluntary and the makeshift more than the public funded professional and institution. There appears to have been a complex interplay between factors that determined the shape of services in localities. Below, the theme will be explored in more detail through closer examination of the development of specific services.

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TABLE 1.1

A comparison of population, birth rate, infant death rate, and the number of children aged 4 or under in Merthyr Tydfil, Tottenham, Oxford County Borough and Oxfordshire in 1921 and 1931

|                       | Year | Population | Area in square miles | Children aged 4 or under |                 | Birth rate | Infant deaths per 1,000 births |
|-----------------------|------|------------|----------------------|--------------------------|-----------------|------------|--------------------------------|
|                       |      |            |                      | No.                      | % of population |            |                                |
| Merthyr Tydfil        | 1921 | 80,116     | 16                   | 8,413                    | 10.50           | 27.5       | 90                             |
|                       | 1931 | 71,108     |                      | 5,350                    | 7.52            | 15.9       | 105                            |
| Tottenham             | 1921 | 146,711    | 4                    | 13,434                   | 9.16            | 22.8       | 67.9                           |
|                       | 1931 | 157,772    |                      | 11,455                   | 7.26            | 14.1       | 52.9                           |
| Oxford County Borough | 1921 | 67,290     | 12                   | 3,720                    | 5.52            | 16.47      | 36.4                           |
|                       | 1931 | 80,539*    |                      | 5,265                    | 6.53            | 15.04      | 44.4**                         |
| Oxfordshire           | 1921 | 122,325    | 637                  | 10,912                   | 8.92            | 19.8       | 55.9                           |
|                       | 1931 | 129,082    |                      | 9,465                    | 7.33            | 15.8       | 30.7                           |

\* Oxford County Borough, area, and population extended after 1929 under the Local Government Act.

\*\* 1931 was an abnormal year for Oxford County Borough, the trend otherwise continued downwards.

Sources: Census figures and MOH A/Rs for the respective areas.

TABLE 1.2

A comparison of the maternity and infant welfare services offered by local authority and voluntary sectors in Merthyr Tydfil, Tottenham, Oxford County Borough and Oxfordshire in 1937

|  | Merthyr Tydfil | Tottenham | Oxford County Borough | Oxfordshire |
|--|----------------|-----------|-----------------------|-------------|
| Infant welfare centres                           | 8              | 4         | 14                    | 12          |
| Antenatal clinics                                | 1              | 2         | 2                     | 0*          |
| Postnatal clinics                                | 0              | 2         | 0                     | 0           |
| Gynaecological clinics (including birth control) | 0              | 1         | 1                     | 0           |
| Day nurseries                                    | 1              | 2         | 1                     | 0           |
| Artificial sunlight treatment                    | 1              | 1         | 0                     | 0           |
| Dental clinics                                   | 1              | 2         | 1                     | 0           |
| Maternity hospitals                              | 1              | 2         | 2                     | 1           |
| Minor ailments clinics                           | 1              | 2         | 1                     | 0           |

\* In 1935, antenatal work in Oxfordshire was contracted to general practitioners by the local authority.

Source: MOH A/Rs from the relevant areas.

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## CHAPTER TWO

### INFANT WELFARE

The Maternity and Child Welfare Act of 1918 grouped all aspects of care for children up to school age together; pre-natal care, midwifery, and care for babies and toddlers - medical care, physical, social, and emotional well-being. Different campaigns and interests co-existed in the field already in 1918, the strongest of which was arguably the infant welfare movement, a diverse but robust movement, run for the most part by women as volunteer health visitors and advisers, at schools for mothers, babies' welcomes, and infant welfare centres. The roots of this movement go back to the later nineteenth century, with visitors to the poor; Anne Summers and Frank Prochaska have described the mixture of practical and home medical help afforded by these visitors, and the 'mothers' meetings' they organised, all set in a strong framework of Christian rescue and prayer.<sup>(1)</sup> As concerns about the physical health of infants grew at the turn of the century, the movement turned its energies to more medical interventions, looking at ways to encourage mothers to seek medical treatment for themselves or their infants. It was no longer enough for women working with poorer mothers to give advice on how to make ends meet; they needed to know about hygiene and the risks of disease, to know when to advise a visit to the general practitioner or the outpatients department, and to work for the local provision of clinics and practitioners, obstetricians, trained health visitors, trained midwives, to whom to refer people.

The history of this movement in the early twentieth century has been very usefully charted by Deborah Dwork and Jane Lewis. Dwork has argued that advice-giving infant welfare centres performed a crucial function in lowering infant mortality rates in England and Wales. In her eyes, the



movement which began before World War I correctly saw education as the key to a successful preventive health campaign. Lewis, arguing from a different standpoint, charts the increasing medical colonisation of childbirth and childrearing through the first half of the twentieth century, seeing the gainers as the professions of obstetrics and health visiting, and the increasing professionalisation of midwifery, not the mothers the movement was designed to help. In her eyes, the Women's Co-operative Guild and its allies campaigned for the real needs of the working class mother - needs for family allowances, housing, free meals and medical attention - only to be turned down by the powerful medical professions and the weight of industrialists who shied away from notions of more taxation and minimum wage legislation. (2)

Both authors have argued from a national perspective, although both have used local studies to enforce their arguments. Looked at locally in these four areas, comparing availability and use of clinics and infant mortality rates, Dwork's argument calls for a certain amount of revision. There are other variables at play in addition to education of mothers through clinics; Tottenham had by far the highest clinic attendance rate, while Oxford City had the lowest infant mortality rate. Statistics taken ward by ward in the four areas unfortunately involve numbers which are too small to be significant, but there are indications that however eagerly education was received, infant mortality remained high.

There is evidence that at a national level, in Whitehall, the Women's Co-operative Guild (WCOG) was an opposition party championing the real needs of working class mothers. Books like Motherhood, Letters from Working Women, Working Class Wives by Marjorie Spring Rice, and Life as We Have Known It are eloquent testimony to mothers' material

hardships and the important role played by the WCOG. (3) Locally things were not always as clear cut. In Coventry, working class women shop stewards ran infant welfare clinics to educate their fellows in modern motherhood. (4) In Oxford, the local WCOG provided tea at the clinics run by the powerful local elite (see below) and otherwise had a low profile in City politics; by contrast in Tottenham, where the WCOG virtually ran the Maternal and Child Welfare committee of the Council which was itself largely Co-operative Labour, education of mothers was at the fore, thrift and self help encouraged, and a thorough means-tested system for services instituted. None of these local examples shows a local WCOG championing adequate housing, free medical treatment, family allowances as they did at a national level. Instead, as appears below, each WCOG found its own level of activity within its local political context.

To explore the complexity of infant welfare themes, the next section details the experience of Oxford City where the voluntary movement remained particularly strong. For comparison, the second section outlines the development of infant welfare in Oxfordshire, Tottenham, and Merthyr Tydfil.

#### Infant Welfare in Inter-war Oxford

A study of the personnel and the services connected with infant welfare in Oxford before World War II demonstrates the continuity of power amongst a social elite, and more particularly the power of the women amongst this social elite. Ideals of less eligibility and self-help, held strongly in Oxford and elsewhere before the turn of the century, continued to influence the shape of welfare provision. Resources made available to the poor were to be kept to a minimum, so as not to encourage dependency, and the poor were to help themselves.



After World War I, Oxford was still dominated by the University. Most employment was in the colleges, the big houses, printing, and the service industries. It was not a town of great poverty, but there were pockets of poor, rundown housing and needy occupants in the cramped courts between the colleges, as well as areas of insanitary conditions in St Ebbes, Jericho, St Aldates, behind the central colleges, and St Clements.(5) Local affairs were dominated by University men, and the other professional elite of any cathedral town, the medical men, solicitors, and churchmen, with their wives and daughters, a few of whom were themselves members of the professions. The Council was politically Liberal or Conservative at this time - at least, the members voted Liberal or Conservative in national elections, though they often ran for local office under personal rather than Party auspices. An old University statute which gave a proportion of seats on the Council to University members, may have reinforced the conservatism of the Council; it certainly left less room for working class or tradesmen's representation. In 1919 there were sixty-three councillors, nine of whom were elected by the University. There were three women councillors amongst their number.(6) For Oxford's councillors during most of the inter-war period, the proper sphere of town government was public sanitation, paving, lighting, parks, and schools. The Board of Guardians dealt with the destitute in the workhouse and Poor Law school, and dispensed some outrelief, although this last was kept to a minimum in Oxford with the help of Alderman Phelps, Provost of Oriel, longtime chairman of the local Charity Organisation Society, and a member of the 1904-9 Poor Law Commission. Welfare work was regarded by Councillors as the sphere of the voluntary organisations and charities: Oxford had a proliferation of voluntary societies, for destitute girls, for the feeble minded, the Oxford Police Aided Society for the Clothing of Poor

Children, the Free Dispensary, the voluntary hospitals, the Nursing Associations, and the Infant Welfare Association. (7)

Amongst all these voluntary organisations, those concerned with infant welfare and the health and well being of poorer mothers are of particular interest at this period.

Maternity and child welfare had been a philanthropic focus since before the turn of the century. This focus, connected originally with the work of late Victorian Lady Visitors, was sharpened by national outcry at the poor health of working class male recruits to the army during the Boer War. The way this national concern about adolescent and adult health was channelled into voluntary and state activity to promote infant health is the subject of Anna Davin's work on 'Imperialism and Motherhood'. (8) The manner in which Oxford's philanthropic elite responded to this national concern followed a pattern of philanthropic activity characteristic of towns and cities throughout Britain. (9)

Nationally, women dominated the maternal and child welfare groups, the sanitary aid societies, health visiting associations, milk banks, societies for schools for mothers and infant welfare centres. The women's efforts, some medical professionals among them, were backed by only a sprinkling of medical men. (10) There were so many of these societies in the first thirty years of the century that one cannot help wondering whether work in the societies was at least as important for the women volunteers and the medical professionals, as for the needs of those being helped. (11) Infant welfare must have seemed a perfect area of voluntary and Council work, at a time when there was a tension for Liberal and Conservative women between their growing presence in the public sphere, and their political need to demonstrate that women's proper place was in the home. Oxford had a large number of such women; public spirited university wives and daughters who wished to make a



contribution to their local community not as experts but as enthusiastic amateurs.

Whether national or local, statutory or philanthropic, maternal and child health and welfare work flourished in Britain during the first forty years of the century. During this period several important laws were passed to encourage infant and maternal health. (see Appendix 2)(12) In consequence, local authorities had an increasingly complex duty in the sphere of infant welfare, an area also catered for by local philanthropic bodies. This might have been expected to lead to conflict or overlap between the statutory and voluntary bodies. In Oxford in particular, with a well established group of women volunteers matched by an active Council Maternal and Child Welfare subcommittee, there might have been clashes. What emerges, however, is a history marked more by co-operation than conflict, where the volunteers helped mould Oxford's sparse public service for mothers and infants to a pattern which fitted their own beliefs as manifest in the voluntary bodies of the City.

Many of Oxford's County Borough Councillors were also staunch voluntary committee members; they kept the rates paid by Oxford citizens as low as they could, as Councillors, and simultaneously devoted their time, a modicum of their money and especially their expertise to the voluntary associations which aimed to ease or improve the lives of the poor of the town. And there were still a great many poor in the town. Sparse services cannot be explained by lack of need. Despite the dramatic changes William Morris and his car factory brought to Oxford, apparent from the mid 1920s onwards, which kept unemployment to a minimum and brought expansion and prosperity to the area, this pattern of voluntary provision and conservative council provision persisted until the later 1930s.(13) Little was spent by the Council on poor mothers and children. For the

period 1919-39 the average spent on all public health services was 1.5% of the Council's total budget: and maternal and child welfare accounted for less than 5%. To give a rough comparison with a borough which had a similar population but a different attitude to welfare, in real figures Oxford contributed between £800 and £2000 p.a. to infant welfare during the 1920s, while Tottenham in the same period spent between £5000 and £7000. (14)

A record of Oxford in the 1920s contains plenty of references to hardship; families living in tents like the man who came from Croydon for work at the car factory, bringing his three children who had previously been confined to the workhouse. He arrived in Oxford only to find housing difficult to find and too expensive even on his relatively good salary of 80s. a week, so with commendable ingenuity he put up a bell tent for himself and his children, having calculated that the only way to keep his children warm and fed was to avoid rent. The NSPCC brought him to trial charged with negligence: The Oxford Times, quotes the following part of his defence:

In Oxford I find they are going to spend £5000 for housing wild animals, but they will not spend anything on housing human beings. (15)

Other families suffering from the housing shortage were split up like this one reported in a letter to The Oxford Times in 1926:

#### The Housing Shortage

In one case a broken-hearted mother has had to part with three of her children, sent to the Cowley Road Workhouse, and has maintenance of 7s. 6d a week to pay for them, and if she cannot get accommodation for them in three weeks two of them will have to go to the Cowley Schools [the workhouse residential school]. Oxford City Council can act fast enough in making motor parks and



garages; why don't they make a supply of proper houses for such families to live in? I think the City Council ought to wake up, and give this mother a house so that she and her husband can have the little ones with them. (16)

Statistics from the voluntary societies also give an indication of hardship; the Oxford Police Aided Association for the Clothing of Poor Children distributed 397 garments (all conspicuously marked and only lent, not given) and 70 pairs of boots in 1922. Some 1664 garments and 280 pairs of boots were distributed during 1937-8. (17) There seems little doubt of the existence of need in inter-war Oxford.

One of Oxford's foremost voluntary societies was the Infant Welfare Association, whose work started in 1905 as part of the responsibilities of the Sanitary Aid Association (SAA), itself begun in 1902 'for the purpose of improving sanitary and housing conditions and general health in Oxford'. (18) In 1905 they were known as the Health Committee of the SAA, set up to educate poor mothers in child rearing in order to protect their infants from disease and death. (19) Some inner wards of Oxford had high infant mortality rates. The volunteer health visitors of this association claimed responsibility for a dramatic reduction in these rates by 1909, even after 'allowances for climatic conditions the Committee believe this decrease tends to prove that their work is really bearing fruit in an increase of knowledge of the laws of health among mothers'. (20)

The Association continued activities during World War I having become the Oxford Health and Housing Association in 1912. This amalgamation occurred because it was recognised at the time that housing and infant health were intimately linked: by 1921, however, public attitudes had changed, and the two functions were separated, one wing becoming the Infant Welfare Association (IWA). This association is

interesting from several points of view. Its committee demonstrates a remarkable continuity of membership from 1902 to 1952 when the IWA finally disbanded. Brian Harrison has described these dominant women. (21) High on the list is Mrs Prichard. As reported in Chapter one, she was married to the Professor of Moral Philosophy, and had been one of the quartet of dons' wives who set up the Sanitary Aid Society in 1902. She continued in this group until the end, following its many metamorphoses. Co-opted onto the Council subcommittee for Maternity and Child Welfare in 1919, she became Chairman in 1925-31, and Vice Chairman 1931-7. (22) In 1919, Mrs Prichard stood unsuccessfully as a Conservative candidate for East Ward, on an infant welfare platform. She finally became a Councillor in 1924 by standing for the University. Mrs Prichard was active in several other bodies in her long life of public service; the voluntary Association for the Feeble Minded, the Council Mental Deficiency Committee, the Council Education Committee, the Old Age Pension Committee, the Watch Committee, the post 1948 Children's Committee, and the NSPCC. As a young woman, enjoying the companionship of philanthropists Mrs Arnold Toynbee and Mrs T. H. Green, she had been influenced by the teachings of T. H. Green. Mrs Prichard had been a committee member of the Women's Co-operative Guild (Oxford's version was rather genteel, showing lantern slides of Italy to the respectable working class of Jericho) and a member of the local Christian Social Union, also rather more paternalistic than it appears to have been nationally. (23) Mrs H A L Fisher was also part of the founding group of the Sanitary Aid Association, although by the inter-war period she had moved on to national prominence as a writer and campaigner on 'Citizenship', and the founder of the Association for the Unmarried Mother and her Child. She retained her interest in the voluntary movement throughout, and she wrote that:

Fortunately in this country of ours, with its strong



instinct for social organisation, its traditions of self-help, there is probably no great danger of limiting unduly the possibilities of the voluntary workers. But there is some danger, however slight, and it is well to remember it, and to understand and appreciate the scope and the value of voluntary work. (24)

Mrs Wells, married to the Warden of Wadham, and Mrs A L Smith, married to the Master of Balliol, were the remaining members of the original quartet. Both remained active in infant welfare into the interwar period. Mrs Wells, another first class honours graduate from Oxford, had been co-opted with Mrs Prichard to the Council's Maternity and Child Welfare Subcommittee in 1919. These four powerful women embraced voluntary and statutory responsibilities. Their circle included the publicly employed Dr Ormerod, Medical Officer of Health, and Alderman L R Phelps, Provost of Oriel, Chairman of the Board of Guardians and Chairman of the Charity Organisation Society for many years. The IWA's work, and the connection of this work with the City's growing public health department through the 1920s and 1930s, is an example of the changing relationship between voluntary and statutory agencies, relating to services for mothers and children. In this case the voluntary society's activities kept a check on the public health services. The attitudes of the IWA committee, attitudes applauding self help, suspicious of the long term use of free material and medical help, persisted, ensuring that, although advice abounded, milk, medical treatment, convalescence and nurseries had to be paid for by those who used them.

There were twelve Infant Welfare Centres operating in the County Borough of Oxford in the 1920s, strategically placed to encourage the less well off to attend. The following quotation is a description of one by Mrs A L Smith:-

groups of from forty to sixty [mothers] allow a

real intimacy between the helpers and the helped: problems are talked over, lifelong friendships formed, sunshine brought into the lives of the plucky, struggling mothers, and not less into other lives which, like my own, lacked for many years such a sphere of usefulness. (25)

On the surface this passage evokes a lively set of relationships between women of different social classes in inter-war Oxford. Closer examination raises some questions; what of mothers who lacked 'pluck'? (And what is pluck anyway?) What did Mrs Smith mean by 'sunshine' which she thought was brought into the lives of the helpers or the helped? How important to her, or to the other Oxford helpers, was the 'sphere of usefulness' that the clinics represented? Recent work by Hilary Marland on the nationally acclaimed Huddersfield experiment suggests that the tangible help for poor mothers and infants brought by Mayor Benjamin Broadbent's infant welfare initiative was negligible in comparison to the national acclaim this activity won for Mr Broadbent himself. (26)

Clinics for mothers and babies were a feature of life in most parts of Britain in the inter-war years. They were held in the poorer districts of many British towns and cities, and also in a number of villages. Some clinics, like the one run by Mrs Smith, were run by volunteers - always women, often (although not always) wives and daughters of professional men, highly educated and capable, but not in paid employment. Medical practitioners and nurses or health visitors, paid from a mixture of rates and national grants, ran clinics in other areas, or regularly attended local volunteer-run clinics. Physically, these clinics ranged from purpose-built premises equipped with weighing scales, examination couches, and consultation rooms, to draughty church halls hired for an hour once a month. Mothers who attended received advice on the various



aspects of childrearing, from feeding to clothing and how to manage difficult behaviour. They might be given the chance to buy recipes, magazines, wool, malt, dried or fresh milk, or a range of other goods at cost price. The doctor or health visitor would on examination advise mothers to take children to their medical practitioner or the hospital outpatients if there was anything wrong; it was not the clinic's role to provide treatment, merely to give guidance on the prevention of ill-health.

What did Oxford's clinics offer? In 1905 the Sanitary Aid Association began a scheme of voluntary health visiting for all Oxford's notified newborn, and persuaded the councillors to provide a bottle of disinfectant to be given free to mothers on infant registration.(27) For a short time, Oxford ran a milk scheme, to provide cost price fresh milk to poor mothers, but this venture was abandoned and instead the committee concentrated on the following: a mothers' thrift club, series of talks on child rearing, a comprehensive health visiting scheme for poorer mothers, a scheme for selling babies' bottles at cost price, a pram leasing scheme, and weekly or fortnightly baby weighing and advice clinics for mothers.(28) In 1919 there were seven of these clinics, and in 1939 thirteen. Gradually through this period the local council Public Health team - health visitors and medical practitioners/medical officers - assumed greater prominence, and the volunteers and the Infant Welfare Association fell into a supporting role. Infant welfare clinics became one of a range of 'official' services for mothers and infants provided in the late 1930s:- ante-natal clinics, a maternity wing of the Radcliffe Infirmary (the local voluntary hospital), a nursery school, a hospital infant treatment clinic, along with the old 'voluntary' groups such as the National Society for the Prevention of Cruelty to Children and the Oxford Police Aided Association for the Clothing of Poor Children.

July 1917 was a time of intense activity for infant welfare campaigners throughout Britain. National Baby Week had been arranged, instigated by the National Baby Week Council, to stimulate local efforts to reduce the number of infant deaths amongst British working-class families. A film was produced, which local groups could hire; speakers were available on invitation, and local councils and voluntary groups were invited to participate. (29) The response of Oxford's voluntary association, now called the Oxford Health and Housing Association (OHHA), was to arrange a full programme of talks, processions, baby shows, demonstrations, open days at the Infant Welfare Centres, and twice nightly showings of the National Baby Week film 'Mothercraft'. The stage management of the event was left to Mrs Wells, Mrs Prichard, and Mrs Fisher, who formed the executive committee of the Oxford Health and Housing Association; it was they who had persuaded their president, the celebrated Sir William Osler (Regius Professor of Medicine), to make the opening speech before the first showing of the film. As mentioned in Chapter One, Mrs Irving, a well known actress who starred as a health visitor in 'Mothercraft', came to Oxford to help with National Baby Week; her brother, A L Smith, was the then Master of Balliol, and his wife was on the OHHA committee. These were powerful figures, in national as well as local spheres. According to reports in the Oxford Journal and the Oxford Times, National Baby Week was a huge success; the film played twice nightly for five nights, to packed audiences, and judging from the pictures of local mothers and babies at teas on Balliol College steps and in Oriel College's gardens, Oxford's poorer mothers were prepared to take their part in the proceedings. (30)

The message given to Oxford citizens during this week was that they should produce more babies, to be reared to a new standard of excellence through the advisory work of the



OHHA. There was also a recognition at this point in World War I that rearing healthy babies also depended on the availability of good housing and good wages. Sir William Osler mentioned this in his speech, and the Oxford Citizen's Association, which had Wells and A. L. Smith on its committee, campaigned for public housing and better public health in Oxford. This period of World War I appears to be the only time until the late thirties when Oxford's elite recognised the importance of material wellbeing to infant health. Before and after this, mothers and infants were seen as in need of advice, not services or material goods. Volunteers could provide much of this, but the OHHA committee recognised at this period that some expert medical advice might be needed, and medical obstetric and paediatric skill ought to be available in the city: 'the city would do well to make the appointment of a lady as assistant Medical Officer of Health a permanent feature of its Health staff'. (30) Voluntary subscriptions would not be enough to pay these fees and wages, so state grants were applied for. The OHHA Annual Report of 1918-19 pressed for publicly financed medical advice for mothers and infants - health visitors, general practitioner medical advisers, and a properly supervised maternity home, to augment the work of the volunteers. (31) Earlier, the OHHA had successfully campaigned for official health visitors to work with referrals from the volunteers, and an out-patient clinic for sick babies at the Radcliffe Infirmary. The Maternity and Child Welfare Act 1918 made grants available to councils and voluntary organisations for a wide variety of facilities, from free meals and holidays through to health visitors and inspectors of midwives. Oxford, its Council and its voluntary bodies, continued to provide more advice than help. Six maternity beds were available in the Radcliffe Infirmary Maternity Home which opened in 1920, secured by a 50% annual government grant of £500, but mothers paid for their confinements unless they could prove hardship. A

National Milk Order of 1919 allowed councils to provide free milk for mothers and infants; Oxford made milk available, but only after applicants had been assessed by the Medical Officer of Health, paid for the milk themselves, and claimed the money back from the Town Hall. (32)

The OHHA retained its influence over public maternal and child welfare in Oxford very simply. The Maternity and Child Welfare Act decreed that a maternity and child welfare committee or subcommittee should be constituted in each local authority, or maternal and child welfare affairs should be dealt with by an existing committee, and that these committees should contain at least two women, to be co-opted if necessary. (see Appendix 2) Oxford's two women were Mrs Prichard (not yet a Councillor) and Mrs Wells. Oxford's provision remained limited. Infant welfare never regained the public prominence of the period between 1917 and 1920. Free provision was harshly means tested in comparison with other authorities, and take up was small, perhaps because of the process to which the applicant was subjected. (33). The major extensions of provision - the appointment of a Maternal and Child Welfare Assistant Medical Officer in 1933, the employment of general practitioners in infant clinics for advice, the setting up of two ante-natal clinics in 1932 and 1934, and the opening of a birth control clinic for the very sick and very poor in the Radcliffe Infirmary in 1935, were due in the first instance to Ministry of Health criticism, and finally to the energy and determination of the Medical Officer of Health and Dr Mary Fisher, the Assistant MOH for Maternity and Child Welfare from 1934. (see Chapter 5) Power slipped from the IWA under the Local Government Act of 1929. This Act meant that all voluntary bodies ceased to make contracts and obtain grants from the Ministry of Health direct, and instead obtained them through their local authority. The IWA clinics were as a consequence taken over by Oxford



County Borough Council, and the volunteers who ran the clinics demoted to volunteer helpers, in 1936. (34)

Many infant welfare centres in Oxford retained an aura of church visiting, something the rich did to the poor, left from the era of T H Green. The following succinct and effective descriptions come from the Public Health Survey, carried out in 1931 by government inspectors from the Ministry of Health.

Nine welfare centres are run by the Oxford Infant Welfare Association, and two taken over on the extension of the City boundaries, by the Council direct. A grant of £57 is paid to the Voluntary Association. One of the criticisms of the scheme has been that no doctor attended these centres. This was remedied last year, and Dr Hill [the MOH] now endeavours to attend as often as possible at ten of them. The eleventh, held at Cowley Road Congregational School, is run by a Mrs A L Smith, on the lines of a mothers meeting, and it is not considered worthwhile sending either a doctor or a Health Visitor. It receives no share of the grant. Health Visitors attend all the other centres. No treatment is given; the babies are weighed, and dried milk, malt and oil, and baby clothes are sold at cost price. Formerly short talks were given, but the meetings are now too crowded and these have been abandoned. Dr Hill tries to examine every new child, but his visits are necessarily somewhat irregular. It is hoped that the appointment of a new Medical Officer will make it possible to have a doctor always in attendance. I visited several of the centres and although they were somewhat crowded, the standard of accommodation and the facilities offered were up to standard. Dr Williams asked me to visit particularly one at Alma

Place, which he hopes someday to close. Here some thirty or forty children and their mothers were crowded into a small upper room which could only be approached by a narrow winding staircase. The room was lit by gas and had a distinct smell of gas, in addition to being stuffy and overcrowded. Dr Hill, looking like a fortune teller, was trying to examine children in a corner of the room behind a green and red curtain. His accommodation here was in marked contrast to that at another clinic, where he examines children in the chancel of a church. (36)

Spiritual nurturing was in fact still part of the agenda for mothers' education, as it had been in the Mothers' Meetings of the nineteenth century. (37) Dr Mary Fisher, herself a 'university wife', still remembers with some amazement her interview for the Medical Officer's job in 1934, when Mrs Prichard, then Chair of the Maternity and Child Welfare subcommittee, asked for assurances that a concern for the spiritual welfare of Oxford mothers would take priority in her work. (38) It is interesting to note that Dr Fisher herself, an employed medical professional, was a University wife, in common with the women who ran the Infant Welfare Association, though not of their circle.

The gradual extension of Oxford's helping agencies, and the gradual decrease in the power of voluntary bodies, superficially looks like a perfect example of the road to the British Welfare State provision of the 1940s. (39) Looked at in more detail, it has been possible to discern another contradictory theme; that of the continuing presence of the powerful men and women of the voluntary agencies within the newer Oxford County Borough Council services, acting as a wet blanket over Oxford's free services, and limiting the scope of rate financed provision at least until the 1940s. The same names appear on the executive



committees of the IWA, the NSPCC, and the County Borough Maternity and Child Welfare sub-committee; the same values that had driven the formation of the Sanitary Aid Society in 1902 continue in the County Borough Council's Annual Reports of the 1930s. This continuity of Victorian Liberal England has been noted in a more general context elsewhere by Michael Freeden, who has argued that the Victorian Liberal interest in developing 'character' was deepened to embrace an interest in social reform to accompany this notion. 'It became a question of reforming the framework in which the individual functioned .... inasmuch as moral improvement depended on factors beyond individual control ... social reform had to assume responsibility over a new domain'. (40)

Compared with state infant welfare facilities in other parts of Britain, facilities offered to mothers and children were few. In Tottenham, for instance, a moderately wealthy greater London borough, by 1936 mothers and infants could choose from a wide range of hospital and midwifery services, minor ailments clinics, creche facilities, in addition to post- and ante-natal clinics, and the ubiquitous infant welfare clinics. Tottenham's 1930s premises were for the most part modern and purpose built, arranged in easy walking distance of all the borough's mothers, open many times a week; Oxford's draughty halls were in sorry contrast to this. Tottenham provided medical services, food, simple medicines, convalescent holidays, and creche places free to families who passed a generous means test; Oxford's range of 'free' services extended only to milk, (vitamins during the 1930s), outpatient infant consultation, and a very few confinements; Oxford's means tests were both stricter and more difficult to apply for than Tottenham's. Tottenham lacked an equivalent band of powerful Conservative women volunteers. Occupants of the larger houses moved further into the country as London expanded, leaving Tottenham to be dominated by members of the Co-operative Labour party, and

members of the Nonconformist Brotherhood (many of them tradespeople), who willingly put their weight behind good public health provision. (41)

The particular shape of infant welfare provision in Oxford was strongly influenced by a group of University wives who found in this work a 'sphere of usefulness' for themselves. The ethos pervading the public and the voluntary elements of this welfare work was a Liberal, or Conservative one. Mothers should be advised, and befriended, their spiritual welfare should be kept in mind, material help should be hard to obtain and only available in cases of illness and desperation. Bringing 'sunshine' into the lives of 'plucky' mothers cost nothing, but gave the appearance of a 'real' gift of health at a time when sunlight was seen as one of the most efficacious preventive health aids available. The infant welfare volunteers were an able group of women, who contributed a great deal to Oxford's civic life. But their response to the real material needs of mothers and children in Oxford was negligible, except in the brief period of post war reconstruction from 1917-20.

What was the impact of Oxford's brand of maternal and child welfare on the lives of the people who were to be helped - the poor mothers and their infants? As mentioned in Chapter One, Deborah Dwork in her book War is Good For Babies advances the theory that the infant welfare centre, dispensing advice on modern motherhood, may have been a rather economical response to problems of high mortality and morbidity amongst infants, but was nonetheless successful. With this argument, Tottenham's Council could be accused of overkill, providing for the sake of civic pride a more elaborate service than was necessary. To measure the success of Oxford's provision, changes in infant mortality rates in Oxford 1900-40 follow, together with one mother's memories of pregnancy and childcare in the 1930s in Oxford.

Infant mortality rates in Oxford, as a whole maintained a steady downward trend from the turn of the century, rather before the Sanitary Aid Association was formed. They began lower than the national average, and fell in parallel. (42) At the time, infant welfare activity was accepted as the cause of the fall, but with hindsight the causal link is not so certain. Only a certain proportion of women attended the clinics, and many attended only once or twice. The mortality rates themselves, broken down by ward, show considerable fluctuation, even in areas with regularly large numbers of births. This is not to say that the clinics fulfilled no useful purpose; many women interviewed by Glyn Williams both enjoyed going to the clinics and were profoundly influenced by what they learnt. (43) One Oxford informant went to the clinic 'once, but never again ... it was unhygienic ... the baby wet the seat ...' She had rather a different view of infant welfare centres. She resented being checked up on 'by ... stuck up volunteers.' She and her friend were keen on new motherhood methods, but they learnt these from magazines and the local chemist, not the clinics. (44)



### Infant Welfare in Oxfordshire, Merthyr Tydfil and Tottenham

Statistics for infant welfare clinics and attendances are often not quite what they seem. Oxfordshire records thirty clinics in the late 1930s.(45) These were held in village halls on average twenty times a year for an hour or two with a visiting general practitioner present and one of the county's fourteen health visitors. The clinics were not easily accessible to mothers. The infant welfare clinics were run by committees of volunteers who understood this problem, and asked the Public Health Committee for a bus service to overcome it. However, the Council turned down the application on the grounds of expense. Another local committee reported running a volunteer car service for mothers from outlying areas.

What was available in these thirty clinics varied widely, depending largely on the local voluntary committee which organised them. Dr Victoria Smallpiece remembers visiting several as a young general practitioner; there was one where there were no facilities for washing, although another had a very competent health visitor who ran the Clinic like a surgery. Dr Smallpiece gave advice, and where she felt it was necessary referred patients on to their local general practitioner for treatment. Some of the clinics had patterns, Virol, and dried milk, providing mothers with a place to meet and talk, while some were more basic.(46)

Merthyr Tydfil's clinics were run by the Assistant Medical Officer of Health for Maternal and Child Welfare. Their main function (see below, Chapter 6) seems to have been to dispense free milk for babies under one year old whose parents were unemployed. There were few volunteers on the



Oxford model; those few solicitors' and vicars' wives that existed ran the poorly subscribed District Nurses Association. (District Nursing Associations functioned on annual subscription from those who could afford it) As outlined in Chapter One, Merthyr Tydfil's working-class families were proud of their mothers' skills and methods and dubious about Mrs Edmund's campaign to teach mothercraft and housecraft in the local schools. Being taught hygiene and modern methods of upbringing would have been nothing short of insulting when, as one informant colourfully related, there were stories of babies eaten by rats in their sleep, and mothers so poor and hungry they were forced to 'eat the bread poultice off their wounded hand'. (47) Giving free milk, or helping distribute the free Marmite, Dorsella, and Ovaltine donated by the National Birthday Trust might well have seemed more relevant.

Tottenham's clinics, as related above in Chapter One were accessible and thorough. They had mothers' committees which provided the tea, mothers' thrift clubs, health visitors and specialists for advice. Through the clinics, mothers could book for midwives, a place at the day nursery, free milk, convalescent treatment, or an appointment at the various minor ailments clinics. Staff had to do some lengthy means test sums, but this was in the interests of targeting the Council budget on those most in need. As in Oxford, the clinics were first established in Tottenham before World War I by a voluntary committee. A school for mothers had been opened in 1912 by "philanthropic ladies". This was taken over by the Council in 1916, and became one of the four municipal centres in operation after the Maternity and Child Welfare Act of 1918.

I quote in full from two descriptions of the early years of infant welfare in Tottenham in order to isolate differences and similarities with the Oxford County Borough experiences:

Dr Seekings Friel [Assistant Medical Officer of Health] was an inspiring acting Chief (The MOH was at this time very ill.) She suggested in 1911 that we should start a school for mothers (almost unheard of in those days.) She pointed out that if we called it a "School for Mothers" the Board of Education would help us with the Financial side (50% of approved expenditure) She suggested that we tried to raise £100 between us. She had been promised £50 by the Women's Imperial Health Society on the condition that we could raise the other £50. We organised whist drives, Rummage Sales Etc. The present Superintendent visited the factories and appealed for help. Finally a friend gave £10 to the Supt. and the £100 was complete. In 1912 Dr Seekings Friel and Mrs Kent Parsons and a few lay friends rented a house in St. Ann's Road- that district was chosen because the Infant Mortality Rate was highest. The first day we opened 23 mothers presented themselves for advice or through curiosity. These mothers had been rounded up in the morning by the present Supt. and her colleague. Free dinners and milk were supplied to nursing and expectant mothers and children under five years. A penny bank was started - laundry work cooking and sewing lessons were given by our enthusiastic helpers ... The work made great progress but has always been badly housed - just makeshift buildings. Our premises had to be obtained by guile- years ago the Chestnuts was a library. During the late War we kept murmuring 'Babies before Books'. Eventually we were allowed to enter, never to depart. Bruce Castle was a museum. Again we murmured "Mothers before mummies". Rooms in Bruce Castle were lent to us ... Mothers [at the School] are taught to cut down clothing and make new garments, ... while women are sewing simple talks on hygiene are



given ... Simple drugs, Virol, Cod Liver Oil & Malt and Glaxo were given or sold at cost prices. Tea was provided free of charge ... dinners given to necessitous cases ... on three days per week. (48)

In Tottenham infant welfare work was headed from the start by professionally trained and employed staff, unconstrained by the band of zealous volunteers operating in Oxford. There is apparent a marked difference in the balance of power between Dr Seekings Friel and her 'enthusiastic helpers' on the one hand, and Mrs Prichard's stern interview of Dr Mary Fisher in Oxford on the other. This may account for the differences in what was on offer in the two localities. Oxford's elite, in their concern to ignore the 'undeserving poor' may have denied themselves this very tangible way of providing help. In both localities, the work was financed by 'guile'; pleading, sales of work, grants, and in both advice and 'education' figured centrally.

#### Clinic Attendances and Infant Mortality Rates in the Four Areas

Infant mortality rates were and still are the most widely used measure of infant health. The larger the population measured, the more significant these indices are; national figures are a more reliable index than local figures, figures for a town more useful than figures for individual wards. For this reason, local statistics are of limited value, year by year. They become more robust collected over time, as they are below. If attendance at an infant welfare clinic caused better health this ought to be reflected in the infant mortality rates. Dr Kirkhope in Tottenham was quite sure of the connection, and demonstrated it in his Annual Reports by measuring the infant mortality rates among his clinic attenders as opposed to the rest of the population; I have included these figures in the tables.

However, with hindsight, although the figures are interesting, the causality might be the other way round; better health as measured by infant survival may have increased mothers' interest in the clinics. The figures comparing the changing pattern of visits to infant welfare clinics in the four areas, and infant mortality rates in the four areas are set out below.

A more detailed discussion of how useful mothers found infant welfare work follows in chapter 5, and of the hidden costs of advice in chapter 4. What remains most striking from the descriptions above is the differences, not the similarities, between infant welfare centres in different parts of the country.



Table 2.1

Infant mortality in four quinquennial periods from 1920 to 1939 in Oxford, Oxfordshire, Tottenham, Merthyr Tydfil and England and Wales. Infant Mortality Rate (IMR) per 1,000 live births and total infant deaths.

|                   | Period  |                   |         |                  |
|-------------------|---------|-------------------|---------|------------------|
|                   | 1920-24 | 1925-29           | 1930-34 | 1935-39          |
| Oxford CB         |         |                   |         |                  |
| IMR               | 49.7    | 51.7 <sup>1</sup> | 45.0    | 33.6             |
| Number of deaths  | 223     | 230               | 268     | 234              |
| Oxfordshire       |         |                   |         |                  |
| IMR               | 51      | 51.7              | 47.0    | 39.5             |
| Number of deaths  | 675     | 512               | 358     | 320              |
| Tottenham         |         |                   |         |                  |
| IMR               | 62.5    | 58.4              | 53.1    | 56.8             |
| Number of deaths  | 1038    | 746               | 601     | 334 <sup>2</sup> |
| Merthyr Tydfil    |         |                   |         |                  |
| IMR               | 88.4    | 96.8              | 86.6    | 78.8             |
| Number of deaths  | NA      | 665               | 472     | 370              |
| England and Wales |         |                   |         |                  |
| IMR               | 76.8    | 72.0              | 61.4    | 55.4             |

NA = not available

1. For the years 1921-24

2. For the years 1935-37

3. For the years 1935-38

Source : Annual Reports of the Medical Officers of Health for Oxford County Borough, Oxfordshire, Tottenham and Merthyr Tydfil 1919-39.

Table 2.2

Attendances at Infant Welfare Clinics in Oxford, Oxfordshire, Tottenham, and Merthyr Tydfil at certain periods in the 1920s and 1930s, expressed as total attendances and the average number of attendances per birth.

|                | Total<br>attendances | Total<br>births | Average<br>attendances<br>per birth |
|----------------|----------------------|-----------------|-------------------------------------|
| Oxford         |                      |                 |                                     |
| 1926-30        | 51,453               | 5,353           | 9.6                                 |
| 1935-39        | 163,306              | 12,866          | 12.7                                |
| Oxfordshire    |                      |                 |                                     |
| 1926-30        | 36,240               | 10,671          | 3.4                                 |
| 1935-6, 38     | 48,238               | 6,025           | 8.0                                 |
| Tottenham      |                      |                 |                                     |
| 1926-30        | 113,814              | 12,533          | 9.1                                 |
| 1936-37        | 54,264               | 3,904           | 13.8                                |
| Merthyr Tydfil |                      |                 |                                     |
| 1923-27        | 51,941               | 8019            | 6.5                                 |
| 1932           | 13,603               | 1040            | 13.1                                |
| 1937           | 20,121               | 896             | 22.4                                |

Source: Annual Reports of the Medical Officers of Health for Oxford, Oxfordshire Tottenham and Merthyr Tydfil

Table 2.3  
Infant Mortality Rates for those whose mothers attended Infant Clinics in  
Tottenham

|         |      |
|---------|------|
| 1921-24 | 13.8 |
| 1925-29 | 10.5 |
| 1930-34 | 8.3  |
| 1935-39 | 7.02 |

The following years' figures are missing:- 1920, 1926, 1931, 1936-9.

Source: Annual Reports of the Medical Officer of Health for Tottenham,  
1921-35.

Comment on tables 2.1, 2.2, and 2.3.

Table 1 compares the rates of infant mortality in the four areas: Oxford, Oxfordshire, Tottenham and Merthyr Tydfil. It shows that the IMR in Oxford, Oxfordshire and Tottenham were below the national average for each of the periods studied, and also that the IMR was slightly, but significantly and consistently, higher in Tottenham than it was in Oxford and Oxfordshire. It is interesting that the fall in the IMR in Tottenham between 1920-24 and the late 1930s was not as marked as it was either in Oxford or in England and Wales as a whole. Thus the IMR in Tottenham was below the average (81%) in 1920-24 and above the average (102%) in the late 1930s. Why Tottenham failed to follow the national pathway is worth exploring further; it could be that maternal and child welfare services had achieved their optimum affect very early in comparison with the other areas, because provision was better here from World War I.

Merthyr Tydfil is the odd one out. It had a much higher rate of infant mortality than the other two, and much higher than the national average. The IMR in Merthyr rose to a peak in 1925-29 and then fell at the end of the 1930s; but the fall was no steeper than it was in England and Wales as a whole through this period. I would suggest that two factors are at play here; one is the catastrophically high unemployment figures, whereby well over half the working population were unemployed during a decade - see Table 6.3. The other is the availability of food through the clinics at a period where much of the population was near starvation, which might well have encouraged attendance rates to soar. I can think of no better explanation for the extraordinarily high infant mortality rate than that put forward by Merthyr's Medical Officer of Health in 1927, after he had explained there had been no abnormal weather conditions or outbreaks of disease in



that year; 'Probably improper feeding, the result of economic conditions, are to be held responsible'

Table 2.2 allows us to draw some very tentative conclusions about Infant Welfare Clinics. There is no doubt that these clinics were busy places: the numbers attest to that. And there is no doubt that the number of attendances per birth increased in all three areas. This increase was very marked indeed in Merthyr. This suggests that it was recognised as a black-spot (as indeed it was) with inadequate welfare services in the 1920s. The number of attendances per birth rose from 6.5 in 1923-27 to 22.14 ten years later: a much larger rise than that seen in Oxford and Tottenham.

Table 2.2 offers the opportunity to test a belief which was widely held at the time and given as the primary reason for their existence, that Infant Welfare Clinics would reduce infant mortality. The data in this table do not at first sight appear to support this notion. A substantial increase in the attendances per birth at Tottenham did not produce a corresponding decrease in the IMR. The massive increase in attendances per birth in Merthyr likewise did not produce an equally massive fall in infant mortality. There are, however, many problems - most of them obvious - in the interpretation of the evidence in Table 2.2.

Total attendances and average attendances per birth are crude indicators. We have no way of knowing what is meant by 'attendances', and no way of being sure whether the content or reality of what was recorded as attendances was the same in all three areas.

Table 2.3 shows us that people at the clinics were decreasingly likely to have babies who died. This is partly a case of the blindingly obvious. Dead babies' mothers have no need for infant clinics. However, it could relate to education at the clinics, or it could be that it was because these particular mothers were already alert to potential

dangers that they started attending clinics in the first place, and that clinic attendance counted as one among several precautionary measures taken to safeguard family health. Some mothers at the clinics may have attended purely to obtain supplementary feeds or other material benefits. They may have been bullied into attendance by persistent and bossy Health Visitors. The mothers who attended probably recieved advice on how to look after their babies; but that advice may have been misunderstood or forgotten or ignored, and the advice may itself have been flawed. It is likely that all these confounding factors existed, and it is plausible to suggest that the extent to which mothers were informed and educated was determined by such factors as the social mix of clinic attenders and the attitudes of those in charge of clinics. What worked in Oxford City may not have worked in Merthyr; the clientele were certainly very different. And an over-assertive and unsympathetic Health Visitor could do more harm than good. That we cannot measure such subtleties does not mean they were unimportant.

There is also the widespread and persistent myth which pervades so much of health care: the myth of 'the more the better'. It is possible that a certain level of attendances - an average, say, of five attendances per birth - was better than no attendances at all and had a real effect in lowering infant mortality. It by no means follows that such an effect would be increased in proportion as attendances increased, at least as far as mortality was concerned.

What we can say with certainty is that a fall in national levels of infant mortality in the period 1920-39 was associated with a national increase in attendances at infant welfare clinics. Whether there was a causal connection remains uncertain. If, however, one was to postulate (as very few would today) that infant welfare clinics played the major role in the decline in infant mortality then - while bearing in mind all the provisos stated above about the crudeness of

counting attendances as an indicator of the content of welfare provision - we would expect to see things in Table 2.2 that we do not see. We should expect for example a much greater fall in the IMR in Merthyr, and also a steeper fall rather than a rise in Tottenham in 1936-37. Likewise the gap between the high IMR in Merthyr in 1937 with its 22.4 attendances per birth and Oxford in 1935-39 with its 12.7 attendances per birth should have been much narrower than it was.

In short, table 2.1 and 2.2 do not support the thesis that infant welfare clinics were important determinants of the level of infant mortality. Equally, we cannot say they had no effect at all. We do not know. But the general view - that rates of infant mortality were determined more by social and environmental factors than the quality of medical care and the provision of welfare clinics - this view is confirmed rather than disturbed by the data in these three tables.



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## CHAPTER THREE

### MATERNITY ARRANGEMENTS

#### A National Maternity Service

Several models for the future of Britain's obstetric services were current in the 1930s, only one of which was the consultant-led hospital based service we know today. The favoured national model reflected in the 1936 Midwives Act was known at the time as the 'National Maternity Service', run by local authorities and supervised by the Ministry of Health and the Central Midwives' Board. This service had as its backbone not the obstetric consultant, but the domiciliary midwife. In this chapter I shall look at the shape, availability and cost of maternity care in the four areas. Taken together, these schemes will give some idea of the diversity existing across the nation, and the viability of the Service in inter-war Britain. Like so many parts of maternal and child welfare provision, these schemes were locally planned and administered, but their standards were monitored by central supervision. What must have mattered to mothers in whatever area they lived was safety, accessibility, and cost.

The strengths of the local schemes that made up the National Maternity Service lay in their flexibility, the variety of services they provided, and the continuity of care they were able to offer with other public health services, including the provision of hospital and specialist facilities for a minority of cases. They provided accessible Council clinic facilities at a historical period when general practitioner services were not free to most parturient women; the services of 'the Panel Doctor' were free only to those in the National Health Insurance Scheme, which in practice meant those at work. The great flaw in the Service, from the mothers' point of view, was that these services were not free at the point of delivery; in fact they were only free

to those who could prove their need under a means test. Services, as appears below, were also likely to be cut or skimmed by local authorities trying to save on the rates, or by Ministry officials trying to save money. A by-product of these economy drives was the continued reliance on volunteers, with their frequently 'charitable' prejudices and inability to provide continuity of care.

In Britain the inter-war years witnessed a great concern about the issue of maternal mortality, which contributed to pressures for a national maternity service.(1) Pressure for this service came from a number of influential sources, both medical and lay. Jane Lewis has pointed to the struggle between the consultant obstetricians and the general practitioners of the British Medical Association, with their competing claims for the management of childbirth.(2) In this debate, only trained medical practitioners were thought skilled enough to supervise births, in hospital, nursing home, or in the mother's house. However, many influential voices demanded schemes in which the majority of deliveries would take place at home in the hands of the trained midwife. In 1926 Sir John Fairbairn, who was to become the second president of the College of Obstetricians and Gynaecologists, wrote in favour of a midwife-based maternity service because he believed it would reduce maternal mortality:-

Attendance in normal labour can be left to the efficiently trained midwife with a medical practitioner at her call in case of need, and this requirement may be taken as the basis of the work of the maternity service.

A maternity service based on an attendance by a well-trained corps of midwives under medical supervision with provision for difficult cases is the one most likely to give the best results. (3)

In 1927, in an official report called The Protection of

Motherhood, Dame Janet Campbell, Senior Medical Officer at the Ministry of Health, wrote a plea for

a complete Maternity Service, that is a service which secures every woman such assistance as is needed to ensure for her a safe journey through pregnancy ... such a service might well be based on a scheme for improved domiciliary midwifery in which many normal deliveries and all maternity nursing would be performed by midwives, but always with the active support of the patient's own doctor.

(4)

In the inter-war period, voluntary groups were powerful in the whole field of public health at both national and local levels. They provided many of the services in maternal and child welfare. Lady Rhys Williams who chaired the National Birthday Trust Fund which was dedicated to improving childbirth for 'ordinary' women, was also secretary of the Joint Council for Midwifery which helped to bring the 1936 Midwives Act into being. Jane Lewis reports Williams' belief that the two most important safeguards for motherhood were a good and well trained midwifery service with specialist backup, and adequate nutrition for pregnant women. (5)

In short, with few exceptions, there was broad agreement among all authorities in the 1920s and 30s, from the Ministry of Health and the College of Obstetricians to the voluntary organisations, the general practitioners, and the midwives, on the ideal structure of a national maternity service. Such a service should be based on midwife



deliveries at home, backed up where necessary by general practitioners, or in exceptional circumstances, by consultant obstetricians. There were differences of opinion about how many deliveries should take place at home, and how many in hospital, but these were differences of degree only. Home delivery by the midwife was to be the backbone of the service. Hospital care, supervised by specialists, should be available only for those mothers whom it was felt unwise to deliver at home, whether for medical or social reasons, and for teaching purposes. Irvine Loudon has pointed out that this was precisely the model to be found in Scandinavia and in the Netherlands in the inter-war period. However, he also points to the USA where hospital based delivery was already in the ascendant and home delivery an anachronism, a poor second best. (6)

By 1938 local maternity schemes had been approved by the Ministry of Health throughout Britain. All local authorities, rural and urban, had drawn up their own schemes based on the requirements of their areas. Background legislation and Ministry of Health memoranda and guidelines stressed that adequate domiciliary midwifery should be established for all women, backed up by hospital and other specialist care for those with abnormalities and those defined as 'necessitous', whether through lack of money or inadequate housing. The aim of the legislation and guidance was to make midwifery safe and adequate by building on existing services. The Ministry said that a good maternity service should provide the following: trained midwives, supervised by inspectors, directly employed or employed under contract; ante-natal care; post-natal checkups and gynaecological care; a system of referral to general practitioners or consultant specialists as appropriate; abolition of unlicensed midwives and unlicensed maternity homes; a network of general practitioners and specialists to

be called in emergencies by midwives; laboratory back-up. The backbone of this service was the domiciliary midwife.

In our age of almost total hospital delivery it is difficult to believe that a home delivery system could have been regarded with national pride. But the Midwives Act of 1936 was seen nationally as putting the finishing touches to a mature national maternity scheme based on home midwives. A description of schemes in the four areas under discussion here serves to underline the point, although the trend to a larger proportion of hospital births in relation to home ones is present in all the localities 1919-39. However, as in all other aspects of maternal and child welfare, what is most striking is the differences between areas when it comes to scope, cost, and availability.

If local authorities were seen to provide inadequate services in any area of maternal and child welfare including maternity services, they were faced with the very real threats of inspections, warnings, and withdrawal of grant. Local maternity schemes were funded through the rates and also importantly through Ministry grants allocated for five year plans ratified by national officials. In this service, as in other aspects of public health, the Ministry kept up to date by sending inspectors to carry out Public Health Surveys. (7)

Before turning to the local areas in question, it is worth noting that one of the striking features of these surveys was the extraordinarily wide variation in the quality of maternity services across the country. It is difficult to make meaningful generalisations about maternity services or other public health services in the inter-war period without adding the cautionary note that local variations were far more important than national averages. For example, national percentages showing trends towards hospital births



mask dramatic differences between areas. Urban districts tended to have higher hospital rates than rural districts; more unfit housing, connected with more 'necessitous' cases, and a range of accessible hospital accommodation could dramatically increase the number of hospital deliveries in one area as opposed to another.

#### Maternity Schemes in Tottenham, Oxfordshire, Oxford and Merthyr Tydfil

As described in Chapter One, these areas display a range of different social, political, cultural, topographical, and economic features. Oxfordshire's social structure was that of an old established landed and commercial gentry and an equally well established rural working population, employed on the land, and in blanket and glove making industries. Oxford's car works attracted some men from the County, but in pre-World War II years only a minority. The County Council was dominated by the gentry and the small town manufacturers and tradesmen. (8) These were the people who made the decisions in Oxfordshire about what money to spend on public health and on the maternity service in particular. They were the ones who employed the Medical Officer of Health who ran the County's Public Health department, and it was their wives who ran the volunteer charitable organisations of the county, foremost amongst which was the Oxfordshire Nursing Federation, employer of the county's district nurse-midwives from the turn of the century, and chaired throughout by the formidable Mrs Morrell (see below, Chapter 4). (9)

Tottenham's social structure and Council power base was entirely different. Engulfed by built up areas during the inter-war period, it lost some of its old houses and with them its gentry, gaining instead acres of model LCC housing



estates and some of their own. Its Council was trade and professional, non-conformist, Co-operative Society Labour, full of modern methods and civic pride. In many ways, the Council's responsibilities were less onerous than Oxfordshire's; Middlesex retained many public health functions, including midwifery, until 1930, when Tottenham became an Urban District Council, a status which allowed them direct access to Ministry grants (Banbury in Oxfordshire has largely been excluded from this study because it enjoyed a similar status in relation to Oxfordshire County Council). Also, the numerous prestigious hospitals in the London area ensured a range of medical facilities not available to citizens elsewhere. Tottenham was confined within a compact four square miles, with easy access to neighbouring health facilities to augment its own. The powerful charitable organisations and the gentry to run them were significantly absent from Tottenham; it was the Medical Officer of Health and the Superintendent of Midwives who tried to keep a nursing association alive, unsuccessfully until the later 1930s. (10)

Miners in Merthyr Tydfil had a Union scheme for medical cover outside the National Health Insurance Scheme, which covered themselves and their families. This was unique in the areas studied here. It meant that general practitioner care, free at the point of contact, was common for working-class families of the district. Towards the end of the thirties general practitioners began to mount schemes similar to those employed by voluntary hospitals a decade previously to secure income; Oxford citizens were offered a 1s. a week insurance scheme for general practitioner services. (11) Trades' Unions in the South Wales valleys had employed their own general practitioners for their workers throughout the interwar period; the hero of A.J. Cronin's novel The Citadel is a doctor employed in this way. (12)

However, the crisis in Merthyr during the inter-war period was such that these schemes were not sufficient. The voluntary movement was thin on the ground, barely supporting one district nurse for the area, and the small voluntary hospital was locked in a struggle between Union representatives and employers on the board. (13) The industrial crisis facing Merthyr took its toll, as we have seen; dramatically falling birth rate, soaring infant mortality, and chronic morbidity among children under five. Oxford County Borough's powerful network described in Chapters One and Two had a strong hand in the local voluntary hospital, which was itself further strengthened by donations from William Morris's fortune. There was a long tradition of district nursing stemming from nineteenth-century philanthropic days. However, in line with other maternal and child welfare trends in Oxford, advice to mothers was regarded as preferable to real material or medical help. Having secured specialist obstetric help for the minority who might need it, the Council committees and the voluntary associations, which overlapped so strongly in personnel, left the poorer in the population to manage. The Radcliffe Infirmary's 2d. a week insurance scheme, which secured the hospital's future as well as benefiting those needing hospital treatment, specifically excluded the high costs of the hospital's maternity home.

Admission to the home is not part of the benefits received under the contributory scheme. Inclusion within the scheme would not be practicable because, in the nature of things, only a comparatively small number of people could qualify to receive the benefit, so that the spread of the cost over the whole body of contributors would be inequitable.

(14)



This is a patently thin argument. Any specialist facility in the hospital could have been excluded for the same reason. Mothers instead paid what was referred to as the 'nominal' cost of £3.6s.7d. per week (compared with the cost of £2.2s.0d. per week which the Mothers' Hospital in Clapton charged to Tottenham mothers). (15)

#### The Four Maternity Schemes.

The Ministry of Health requested maternity service plans from all local authorities under the terms of the 1936 Midwives Act. Of all inter-war interventions into local maternal and child welfare schemes, this was the most prescriptive, with the most detailed central rules. Each authority faced different obstacles depending on its makeup; some obstacles were geographic, some economic, some social, and some political. The Ministry was very keen on economy; they wished to minimise the sum they were bound to hand over annually in grants. Looking at geographical factors alone, Tottenham had the cheapest task, with a compact population and four easily cyclable square miles to cover. The estimated annual cost for its maternity scheme, more elaborate than that in any of the other areas, was £3,000 after receipts from mothers. (16) Oxfordshire was more spread out and communications more difficult, so that a service which in comparison to that in Tottenham seemed barely adequate - heavily dependent on charitable donation, and not generous in its allowance to mothers or the training allowed its staff - was estimated to cost £6,000 for the same population size as Tottenham after receipts from mothers and voluntary contributions from local nursing associations. Cars and telephones amounted to £3,400 of the cost of the scheme, estimated to be £13,714 before receipts. (17) Geographical factors played a large part in this difference. Both authorities, as we have seen, had an annual birth rate of around 2,000, although the numbers to



be covered by the home midwifery service varied because of rates of hospital delivery. Ministerial guidelines suggested one domiciliary midwife for seventy estimated home births and thirty maternity nursing cases. Given the annual figures for hospital births, this would have led to twenty-six Oxfordshire midwives and seventeen Tottenham ones. In the event, Oxfordshire argued for sixty district nurse-midwives, which could be seen as the equivalent of thirty full-time midwives, while Tottenham made do, reluctantly, with twelve, having originally requested funds for sixteen.

Oxford's scheme was to cost £2,709 before receipts, £1,314 after receipts. This included wages for six municipal midwives and one 'almoner (or collector)' and some of the wages for five district nursing association midwives, to cover an estimated 800 home births. Actual births in the district had been 1787 in 1936.(18) Interestingly, the report brought to the Maternity and Child Subcommittee in October 1936 estimated an increase in home births for the following year, based on current trends.(19)

Merthyr bid successfully for fourteen midwives, pleading difficulty of terrain:

regard must be had to the peculiar configuration of the Borough and the fact that no Midwife is supplied with a car, and, consequently, long distances have to be undertaken on foot.(20)

The cost of their service was only £2,200 annually; although all the midwives were municipal, and therefore at full cost, the wages offered were only £150 rising to £200, compared with £160-80 in Oxfordshire, a flat £200 in Oxford, and £200 rising to £250 in Tottenham. Where midwives were not municipal, the Council only needed to make up the salary; the four midwives employed by the Radcliffe Infirmary District Nursing Association only cost the Council

£100 each, in spite of the fact that all midwifery fees were reclaimable through the almoner.

The schemes show variation on paper; on the ground differences are even more striking. In Tottenham, everything from home to hospital to clinic was within easy walking distance. There were three ante-natal clinics held on different days and within reach of all pregnant women. These were run by a woman specialist, Dr Esther Rickards, who practiced during the rest of the week at London teaching hospitals. Mothers who were referred to general practitioners or to the hospital either walked to their appointments or could be taken by the Council's ambulance in emergencies. There was full co-operation between the hospitals and the clinics. Most of this service had been operating since the early 1920s with encouragement from Councillors and the Medical Officer of Health and his staff. Once the midwives became the responsibility of the Council, the system ensured great continuity for mother and infant. In addition, there was a service of home helps for the lying-in period, and convalescent treatment and holidays, with or without infants, for mothers in need. A gynaecological clinic offered advice and simple treatment for longer term problems, as well as offering birth control advice and equipment. There had been few struggles in instigating this service, besides those with the Ministry for larger grants. Councillors and Public health staff, under consistently 'inspiring' leadership from the MOsH and superintendents, readily agreed to schemes for improved standards and services throughout the interwar period.

In Oxfordshire, the MOH had the nightmare problem of providing a maternity service for a population the same size as Tottenham's, but spread over an area 184 times as large. Throughout the 1920s and early 30s, the MOH tried to tackle the problem of ante-natal facilities, at one point providing



ten times as many ante-natal clinics as Tottenham, even if they were in inadequate places and open between twelve and twenty times a year for a couple of hours at a time. He eventually persuaded the Public Health Committee in 1935 that the only way to ensure available ante-natal care was to pay general practitioners a nominal sum to make two visits to expectant mothers in their district. Ease of access was one consideration. Another was adequate professional staff and adequate back up services to ensure continuity of care. Most of the village midwifery was carried out by the Oxfordshire Nursing Federation (ONF) nurse-midwives throughout the interwar period. For the ONF, the Midwives Act was welcomed more as an insurance policy against nursing association amalgamations or collapse than as something new in itself. (21) There remained only one Council-employed midwife, operating in Henley, who had been employed in World War 1 and was not to be dislodged now; the rest were all ONF employed. The ONF co-ordinated county village nursing associations, and orchestrated the minimal training which student nurse midwives received - eighteen months to two years. Even after the Midwives Act, the voluntary associations remained very largely dependent on substantial annual contributions from the local landed and professional classes, and a few pence a week from the cottagers. Ministry officials through Public Health Surveys and inspection under the Midwives Act were pressing about aspects of the maternity scheme they found inadequate; by 1939 Oxfordshire had in operation an obstetrician for emergencies, a laboratory back-up service, and an emergency flying squad for county- and city-wide obstetric care. Oxfordshire still had no post-natal clinics, no gynaecological clinics, no convalescent facilities, and only a skeletal home help service.



Facilities in Merthyr Tydfil and in Oxford testify to the importance of prevailing local attitudes. Although Merthyr paid its fourteen midwives from municipal funds, there was little in the way of back-up continuity of care. The local Women's Section of the Merthyr Tydfil Trades Council and Labour Party sent a deputation to the Medical Officer Dr Stephens against the establishment of a voluntary birth control clinic in Merthyr and for a Council birth control clinic; this was turned down on the grounds that Ministry guidelines allowed only a few necessitous or ill mothers to benefit, whereas the voluntary clinic already in existence had a much wider remit. Dr Stephens added that such a clinic would cost £100 to run, which the Council did not have. (22) Food was supplied to expectant and nursing mothers 1935-7 by the National Birthday Trust Fund in Marmite, Colact, Dorsella, Ostermilk and Ovaltine. There were four ante-natal clinics open once a week in different parts of the borough. Dr Strachan, an obstetrician from Cardiff visited Merthyr once a month to see any cases that might have been referred to him for delivery at the Infirmary in Merthyr. Hospital treatment for abnormal cases was provided at the old Poor Law Infirmary. There was no post-natal care or home help service and any convalescent needs were left to charities.

Oxford City had four ante-natal clinics three of which were run by the Assistant Medical Officer of Health, Dr Mary Fisher, and the fourth by the Radcliffe Infirmary Maternity Home. These clinics also provided post-natal care. It had the same specialist back-up services as Oxfordshire, a skeletal home help provision, and no convalescent provision. The story of the Council Birth Control Clinic, set up in 1934, is interesting. Mary Fisher, Assistant Medical Officer of Health for Maternal and Child Welfare, backed by Dr. Harrison Hall, eugenicist, chair of the Infant Welfare

Association, associated with Oxford's Voluntary Birth Control Clinic, and member of the City's Maternity and Child Welfare subcommittee, proposed the inauguration of a Council Birth Control Clinic to be sited in the Radcliffe Infirmary with permission of that voluntary hospital. The press were outraged at what they saw as an attack on the City's morals. Plans were passed for this clinic for the ill, the abnormal, and the necessitous in a close Council vote :33/28. The Council clinic was opened in May 1935 .(23) Here, directly contrary to the experience in Merthyr, the eugenic argument won, which had been recommended in the government circulars to all local authorities in 1934.(24)

There were considerable differences in the shape of these maternity schemes. In practice, and from the vantage point of mothers themselves, the differences become even more marked. In 1937, the situation was as follows. Midwives in Oxfordshire covered a large patch of ten to sixteen square miles, often on foot or by bicycle. There was only one replacement nurse-midwife for the whole county. Only the Inspector of midwives and thirteen of the sixty nurse-midwives had cars or telephones. The emergency obstetrician was used less than once a year in the later 30s, and the back-up laboratory service only two or three times. Large numbers of the 'ante-natal clinics' that existed up until 1935 hardly deserved the name, being held in a makeshift manner once or twice a month in church halls - the low attendance, less than 1.5 attendances per session, reflects their lack of convenience and popularity. In Oxford, midwives had a bicycle and a telephone allowance. Over half of the expectant mothers attended the four ante-natal clinics, which are remembered with enthusiasm by informants.(25) This was where they booked the midwives and could begin to pay by instalments. The busiest Oxford clinic had an average of eighteen women present. However,

only thirty-nine women altogether (roughly 4% of home births) attended for post-natal care. Merthyr's fourteen municipal midwives travelled on foot, although they were given a telephone allowance. Less than 10% of expectant mothers attended the ante-natal clinics. In Tottenham, 53% of all pregnant women attended the clinics in 1938, midwives worked in pairs so there was always a back-up, and post-natal attendances were on the increase. (26)

Unfortunately no data are available on how many mothers were delivered by general practitioners, but there were wide differences between areas on numbers giving birth in hospital. Numbers were rising, but at very different rates.

Table 3.1

Percentage of Hospital Births in the Four Areas

|      | Merthyr<br>Tydfil | Tottenham | Oxford CB | Oxfordshire | E&W           |
|------|-------------------|-----------|-----------|-------------|---------------|
| 1928 | NA                | 20%       | NA        | 9%          | 15%<br>(1927) |
| 1938 | c. 10%<br>(1934)  | 50%       | 33%       | 10%         | 25%<br>(1937) |

Source: Annual Reports of the Medical Officers of Health; .  
Lewis, Politics of Motherhood



Costs and the effect on the family budget were very important considerations in deciding which method of delivery to choose, as were considerations of time and travel. In Oxfordshire, if a woman or her husband were part of the National Insurance scheme through their work, she could expect to get 30s. Maternity Benefit. This could pay the 25s. paid by most people for a midwife in Oxfordshire, and leave a little over for baby clothes and other expenses. If a doctor was called - as they were in 634 cases during 1937 in Oxfordshire - families would be faced with bills of £2-£3 to the Council. (27)

However, to be designated a special case at the ante-natal stage was potentially a financial calamity. A case history exists of one mother who applied for a grant to cover such expenses from the County in 1934. She had to find the 3s. return fare for each ante-natal visit to the Radcliffe Infirmary Maternity Home. She then faced a bill of 14s.1d. per day for a minimum twelve day stay - a total of £8.9s.0d. Employing a home help in her absence was to eat up another 30s. Add to this bill the hidden costs of providing herself and her baby with respectable hospital clothes, and a clear picture emerges of a mother whose family could be going without food, adequate clothing, and warmth for the next year. She was successful in her claim to the Council, but few were in Oxfordshire. In Merthyr Tydfil, hardship from the same causes faced the mother ordered to pay off her debts for Dr Strachan's services at 2s. a week for several years to come mentioned in Chapter One. Maternity schemes were expected by the government to be as far as possible self-financing. Midwives' salaries were expected to be balanced by the fees they collected, emergencies being charged to individuals, not to the rates. Oxfordshire County Council, as we have seen, was, like Oxford County Borough Council, composed for the most part of traditional

Liberal or Conservative men and women who seemed still to subscribe to the notion of the 'deserving poor' and were not disposed to give help lightly. Users of services were expected by these Councils and by the Ministry to pay for everything except check-ups and advice unless they could prove real hardship. In the last three years before the war, around 200 women from Oxfordshire were delivered in the Radcliffe Infirmary. The County Council gave help in only three of these cases. It is unlikely that this reflected the real level of need. In 1937 less than 10% of the fees payable to general practitioners for emergency visits - the 634 mentioned above - were reclaimed by the County Council from the mothers. In this case, the Midwives Act of 1918 had left the Council liable for these practitioners' bills in the first place, although they were empowered to recover the fees later.

Although money was a major stumbling block for mothers using the Oxfordshire maternity scheme, there were others. The district nursing associations who employed the nurse midwives retained a good deal of power even after 1936. In April 1928, an inquest on a baby who had only lived a few minutes was held in the village of Bloxham. It was said that the child would have lived if specialist help had been on hand. The nurse-midwife had been asked to attend, but had refused on the grounds that the patient was unmarried. It was the rule of nursing associations not to attend such cases without special permission from the secretary, which in this case had not been obtained. (28). Despite the inquest, and representations to the County Council and the Central Midwives Board, only a warning was issued.

To maintain standards of midwifery, midwives were inspected from 1902 by the Councils' Inspectors of Midwives. One

record of a failed inspection in Oxfordshire exists where the Secretary of a local Nursing Association objected to having 'her servants interfered with without her permission'. (29)

Oxford mothers faced the same Radcliffe Maternity Home costs, although hopefully not the same prejudices. Tottenham mothers were in a more fortunate position. The Council was sympathetic to their needs, had more lenient means tests, and paid out many more grants. Hospital costs were less than those at the Radcliffe, at £4.10s.0d. for an average stay of two weeks. Although midwifery fees were higher - 42s. for a first child and 31s. for subsequent children - there were generous allowances. The Council would pay the whole midwifery fee for a family of four living on 52s. a week or less after deduction of rent. Fifteen per cent of families in Tottenham assessed for the New London Survey came into this category. (30) In February 1936, a representative month, the Council approved four requests for free home helps, four for maternity hospital fees, and two for home deliveries. In the same month, Councils in Oxford and Oxfordshire considered no such request, while Merthyr approved several requests for help with children - a pair of glasses, thirty requests for cod liver oil, one for artificial sunlight treatment, and the treatment and associated costs of forty-one orthopaedic cases. (31)

These four maternity schemes were different, for the mixture of reasons that attended all locally determined public health services. Rural areas had particular practical difficulties to surmount, while urban areas found they needed to plan for more hospital births. At their best - and Tottenham was one of the best - the maternity schemes



laid down in 1936 provided mothers with continuity of care throughout the neonatal period, and the security of means tested grants for a wide range of services. However, even at their best, there were flaws in the services. The major one was financial. These schemes were never intended to be free to the consumer, which left particular difficulties for the rural mother defined as a 'special case'. The Ministry encouraged cheap schemes. Guidelines following the legislation enjoined local authorities to explore voluntary nursing association schemes before resorting to municipal midwifery, on the grounds of cost. Schemes that paid only part salaries, like those in Oxford and Oxfordshire, were recommended. In this way, mothers were open to social prejudice from the voluntary associations in addition to the financial burdens of modern motherhood described in Chapter Six. For the Ministry, the more voluntary involvement the better, in this as in so many other spheres of health and welfare.

In the majority of cases, little difficulty was experienced by the Authorities in effecting co-operation with the voluntary organisations that employed or were willing to employ midwives in their area. (32)

To prove his point, the Chief Medical Officer goes on to explain that Wales, renowned for its lack of voluntary bodies, had fourteen of its eighteen maternity schemes operating with voluntary assistance in 1937. Merthyr was one of the four rebels.

The desirability of a total hospital delivery system was by no means a universal assumption in the inter-war period. To call the skeleton service outlined above a National Maternity Service seems over grand. However, the licence to

provide a flexible service offering continuity of care at reasonable cost was there for any local authority with the will, the strength and ingenuity to stand up to the Ministry officials.

#### Maternal Mortality in the Four Areas

Just as a connection was drawn between infant clinic attendances and infant mortality figures, so a connection was drawn between ante-natal clinic attendances and maternal mortality figures. Local figures here are even smaller than for infant deaths, and in many ways of even less use as an index of maternal health. However, the table below gives some indication of general trends within areas, and differences between areas.

Table 3.2

#### Maternal Mortality Rates per 1000 live births 1927-39

| Date | Merthyr | Tottenham | Oxford | Oxfordshire |
|------|---------|-----------|--------|-------------|
| 1927 | 6.6     | NA        | NA     | 2.4         |
| 1928 | 9.1     | NA        | NA     | 2.65        |
| 1929 | 4.66    | NA        | NA     | 2.94        |
| 1930 | 3.9     | NA        | NA     | NA          |
| 1931 | 5.69    | NA        | NA     | NA          |
| 1932 | 7.13    | 4.5       | NA     | NA          |
| 1933 | 3.62    | 5.9       | 4.3    | NA          |
| 1934 | 1.8     | 5.1       | NA     | NA          |
| 1935 | 6.4     | 2.9       | 2.23   | NA          |
| 1936 | 1.02    | 1.49      | 2.12   | NA          |
| 1937 | 4.2     | 4.42      | 1.44   | NA          |
| 1938 | 5.9     | NA        | 2.02   | NA          |
| 1939 | 3.3     | NA        | NA     | NA          |

Source: Annual Reports of the Medical Officers of Health; Public Health Survey for Oxfordshire 1931 (33).

Table 3.3

## Maternal Mortality in Merthyr Tydfil 1927-1939

## MATERNAL MORTALITY.

| MATERNAL MORTALITY.              | 1927 | 1928 | 1929 | 1930 | 1931 | 1932 | 1933 | 1934 | 1935 | 1936 | 1937 | 1938 | 1939 |
|----------------------------------|------|------|------|------|------|------|------|------|------|------|------|------|------|
| (a) Total Number — —             | 9    | 12   | 6    | 5    | 7    | 8    | 4    | 2    | 7    | 1    | 4    | 6    | 3    |
| (b) From Sepsis — —              | 2    | 2    | —    | 2    | 3    | 2    | 2    | 1    | 2    | 1    | —    | 1    | NH   |
| (c) From other causes — —        | 7    | 10   | 6    | 3    | 4    | 6    | 2    | 1    | 5    | —    | 4    | 5    | 3    |
| (d) From associated causes — —   | —    | —    | —    | —    | —    | —    | —    | —    | —    | —    | —    | —    | —    |
| (e) Rate per 1,000 births — L.B. | 7.1  | 9.79 | 5.01 | 4.17 | 6.1  | 7.69 | 3.9  | 1.9  | 6.88 | 1.08 | 4.4  | 6.3  | 3.3  |
| T.B.                             | 6.6  | 9.1  | 4.66 | 3.9  | 5.69 | 7.13 | 3.62 | 1.3  | 6.4  | 1.02 | 4.2  | 5.9  | 3.1  |

Source: Annual Report of the Medical Officer of Health for Merthyr Tydfil, 1939.

Figures for ante-natal attendance as a percentage of births are not available annually for the four areas, but it seems that in 1934 60% of all pregnant women in Merthyr went to an ante-natal clinic, 47% in Tottenham, 50% in Oxford, and only 10% in Oxfordshire.

Maternal Mortality in Wales, a Government report produced by Dame Janet Campbell in 1937, provides some commentary on the huge difference between maternal mortality in Merthyr and the other areas. High maternal death rate is connected with high death rates from other causes; maternal mortality is seen in this way as part of the general morbidity of the region. (37) A welter of different possible causes are put forward, from a reluctance in the valleys to embrace the methods of modern hygienic motherhood, to the effects of unemployment, climate, water supply, and size of family. Judging from the material above, attendance at ante-natal



clinics, and comprehensiveness of maternity services were not of themselves key factors.

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## CHAPTER FOUR

### NURTURE OR SOCIAL ENGINEERING? PROVISION OUTSIDE THE HOME FOR THE 2-5 YEAR OLD IN THE INTER-WAR PERIOD.

The maternal and child welfare movement focused on mother and child from pregnancy to early infancy; from five years old the child came under the wing of the state education system. In the infant clinics and the home, mothers - those in the poorer classes - were persuaded by health visitors and medical officers about upbringing methods, to ensure physical, emotional and social growth on 'modern' lines. In the state schools, children were given regular health examinations and referred for treatment, and drilled in religious and moral teaching in addition to their normal curriculum. The two to five year old fitted comfortably into neither arena; they hung around their mothers' skirts and made a noise at the infant clinic and were difficult to 'drill' if they entered the schools. State responses were sporadic and weak; memoranda urging plans for nursery schools arrived in local authorities from the Board of Education in the years 1918-21, again in 1927-9, and more concertedly from 1936 onwards. In periods of retrenchment and recession, this age group were the most neglected. Their champions were the subscribers to the 'nursery school' movement, and the voluntary bodies that focused on child poverty and neglect, the NSPCC and the Save the Children Fund. These champions, and the bodies they represented, underwent an apparent shift in attitude during the twenty years between the wars, evident in the national literature, but also illustrated in these local studies. A desire to keep an eye on the two to five year old for preventive health reasons changed into a campaign to 'pluck the slum mind out at its roots'. (1)

In the foreword to Our Towns: A Close- Up (1943), Margaret Bondfield points to the weakness in present efforts to 'reform certain bad conditions of living'

We must take the needs of the community as a whole, get right down to foundations and build a co-ordinated structure of services which leaves no gap

She describes the poor of the towns as a continuation of Charles Booth's 'submerged tenth',

a hidden sore, poor, dirty, and crude in its habits, an intolerable and degrading burden to decent people forced by poverty to neighbour with it. Within this group are the problem families, always on the edge of pauperism and crime, riddled with mental and physical defects, in and out of the Courts for child neglect, a menace to the community, of which the gravity is out of all proportion to their numbers.

Next to the problem families come those which may be described as grey rather than black; they are dirty and unwholesome in their habits through lack of personal discipline and social standard...Most of them are capable of improvement in better circumstances and if better educated in a wide sense....'

In this survey the authors

looked at the child who sleeps at unseemly hours and runs late and breakfastless to school, who has head lice, impetigo, scabies, who is unwashed and incontinent, who lies and pilfers. They have looked at him, as England was forced to look at him, with shame and a burning sense of neglect and wrong, and they have sought to suggest a means whereby this degradation of childhood can be avoided and the home of the future made, even at its humblest, a better place...Every road travelled has led to emphasize the need to

guide the child's formation in its early years. Every section leads to a plea for the nursery school where habits can be formed, health and nutrition safeguarded and the tender mind ineradicably influenced for good at an age when lessons imprint themselves on the subconscious as well as the conscious mind. It is through tiny children that parents can best be reached and taught.

Margaret Bondfield was well known for her work as a Labour reformer. She was the Chairman of the Women's Group on Public Welfare, the committee which wrote the book in association with the National Council for Social Service and at the instigation of the Women's Institute. The committee was a distinguished one, drawing on the executive committees of the Women's Public Health Officers Association, the Society of Women Housing Managers, and the Women's Institute and National Council for Social Service themselves.(2) It was written in the period following the outcry raised over the state of evacuated children, and as such has to be seen in the light of the war-time agenda of the early nineteen-forties. Nonetheless, the quote clearly expresses a kind of thorough-going social engineering spirit, targeting moral attitudes and standards, stating culturally acceptable and unacceptable social habits as well as unacceptable standards of health, a spirit which was already strong in the 1930s in Britain. The nursery schools built in Oxford, Tottenham and Merthyr Tydfil in the later thirties I would argue all reflect these attitudes which some researchers have seen as part of the movement for social eugenics, a movement which spanned the political spectrum in its support.(3)

In contrast, the picture presented in the four areas during the last years of World War I and the early 1920s, is one in which the physical health of the child was of paramount importance; minds and hearts were not as central to the



state's agenda for pre-school age children as they were to become.

'The race marches forward on the feet of little children' was the inscription on the Baby Show certificates handed out by Mrs H A L Fisher in Oxford in 1919, the first year of the County Borough Council's Maternity and Child Welfare Committee.(4) At that time the belief that work with babies and with young children would benefit the nation, or to use the eugenic language of the period, turn a C3 population into an A1 one, inspired much of the work of volunteers and professionals.

I will begin by briefly exploring national attitudes and contributions to facilities for two to five year olds. There were the proponents of the nursery school movement, as reflected in the Nursery School Association, and in schools; there was the Save the Children Fund which in this country was one of a number of voluntary groups addressing the practical plight of poor families; and the ubiquitous National Society for the Prevention of Cruelty to Children (NSPCC), dedicated to rooting out child abuse and neglect. The government itself also set up mechanisms to encourage the welfare of this age group; the official national preventive health drive, most active in the 1930s, with publications such as the magazine Better Health, and a string of posters and pamphlets aimed at the public, played its part for the neglected years between two and five.(5)

The English Nursery School Association was founded in 1923. Margaret McMillan was its first president. Its aim was to make the 1918 Education Act clause providing for nursery schools, so brutally felled with the Geddes Act, a reality in England and Wales.(6) There were extensive plans for new nurseries in Oxford, for instance, in 1918-19, which were abandoned wholesale.(7) In E.Cusden's history of the

English Nursery School published in 1938, George Newman, Chief Medical Officer at the Board of Education, is cited for his continuing belief, expressed until retirement in 1934, in the nursery school as a preventive force in those critical years for child health and life between two and five. (8) In this book, the following groups are described as the driving force behind the nursery school movement: school medical officers, who, receiving children at five years old, saw this as already too late for much vital preventive work, and set about providing an earlier point for intervention in the child's life; the welfare movement, described in detail in Chapter Two above, dedicated to nurturing the next generation of British citizens; and the new educational professionals dedicated to overthrowing rote learning in favour of the more rounded individually based learning theories represented by Montessori, which translated in practice to learning through play. The two main features of the early phase of the movement were nurture and preventive health for the poor town or city child. 'Nurture' is described :- 'good food, fresh air, regular undisturbed sleep, training in healthy habits, happy association with their fellows, freedom of movement, activity suited to their minds and growing bodies'. Promotion of health or 'preventive health' included washing, treatment of sores and lice, correction of impairments or ailments - rickets, adenoids, dental treatment, eye and ear problems. For Cusden, the vital shift in the movement between the early 1920s and the later 1930s was the emphasis on different aspects of the whole child; the early twenties concentrated on physical health, while educationalists moved on to focus in the thirties on social, emotional and psychological growth. She ascribes the change to cross Atlantic influence, and suggests the thirties were a period of cross fertilisation in this respect; the English alerted the Americans to the use of inner-city nurture and public medical attention, where the Americans exported their



psychological and social theories. Unacknowledged in Cusden's brief history, but extremely important, is the changing relationship between parent and state, mother and nursery teacher, which this expanding thrust represents. Carolyn Steedman, in her biography of Margaret McMillan, describes a change in emphasis from the 1890s to the 1910s, which she ascribes to the 'increasing politicisation of motherhood before and during the First World War':

in a good deal of McMillan's writing about Deptford, both contemporaneous and reflective, mothers figure in a relationship with their children, as they had not in the Bradford years

This had shifted again by the later thirties. The nursery school movement wanted the child for as long as possible, reducing the contact with the 'slum' mother, hoping to negate the influence of the home, or to influence the home through the child, not in partnership with the parent. (9)

The Save the Children Fund carried out a major piece of research into child poverty in 1932. The publication of its findings chides the government for making the receipt of help during the Depression such a stigmatising experience, praised the material help given through maternity and child welfare centres, to infants, and suggested that 'services for children between two and five are urgently necessary on the grounds of public health'. (10) Their response was to put money into distribution of food, and provision of nursery schools, in selected areas worst hit with unemployment; this included a school at Dowlais, Merthyr Tydfil.

#### Provision for two to five year olds in Oxfordshire, Oxford, Tottenham, and Merthyr Tydfil

Immediately we enter local territory, the larger national debates change focus, subsumed in the strength of local debates, personalities, circumstances and beliefs.



Tottenham had a day nursery throughout the inter-war years, run by the Council under the Maternity and Child Welfare Committee, in specially adapted premises. This was a facility for working parents; charges were means tested and smaller than those in neighbouring boroughs such as Edmonton; it was well equipped, with indoor and outdoor toys, and professionally staffed. It was as deliberately unstigmatising as the rest of their services, well publicised and accessible. It was open from 8a.m.- 6 p.m. (11)

Because of the policy to integrate School and Maternity and Child Welfare Health clinics at Bruce Castle and in the model clinic opened in 1937, children up to five had easy access to minor ailments clinics and their mothers had easy access to advice and treatment. However, there was no schooling for the under fives. None of the schools had nursery classes. The first nursery school in Tottenham was a purpose-built one for children with special needs, paid for jointly by health and education; this opened in 1938. These were not facilities to combat the 'slum mind'; they were logical expansions of a systematic public preventive and curative health service, which Dr Kirkhope and his colleagues had long argued was the proper sphere of local government public health departments.

In the administration of Health Matters, no real and final distinction can be drawn between *preventive and curative methods*, and both spheres should be placed under a common Department.

He went on, in this open letter to the Council in 1918, to point out that a Ministry of Health should be a central authority

Created to protect, maintain and improve the health of the nation as a whole and every unit of the population in particular. It is not particularly concerned as to whether your age is under 5 or between 5 and 14,

whether you are a seaman or a landsman, or a soldier  
or a civilian ... it is essential that a  
Ministry of Health with a wide conception  
of its functions should be set up. (12)

The situation in Oxford was very different. There was no  
day nursery. Women's employment was largely confined to the  
domestic sphere, and informants have talked of ad hoc  
arrangements with neighbours, or taking infants with them to  
the houses they cleaned. Infant clinics were, as appears  
above in Chapter Two, for advice and referral, not for  
treatment. Older children were discouraged; with no purpose  
built clinics, any child older than a baby was potentially  
disruptive, tearing up and down the church aisles or getting  
impatient in cramped upstairs rooms. However, in schools  
things were slightly different from Tottenham.

Traditionally, Oxford had admitted three to five year olds  
into 'Babies Classes'. In 1936 twenty such classes  
containing 673 children existed in the City, as well as the  
125 under 5s accommodated in classes for older children.  
(Around one child in four therefore attended school between  
three and five in Oxford). (12) These classes relied on the  
'imagination and inventiveness' of the individual  
headteachers, who transformed 'old rooms into bright new day  
nurseries' to give this age group a 'nursery' experience.  
Informants remembered the toys, the coloured chalks, and the  
rest times - with newspapers to cover them instead of  
blankets. (14). In addition, a purpose built nursery class  
was opened in Donnington in 1938, within a ring of new  
estates. Here, children had to attend for whole days, and  
were given lunch, baths, plenty of fresh air, medical  
attention, and rest. Far from being kept out, mothers were  
encouraged to assist in the class, which was seen to serve  
the needs of families rehoused from the old overcrowded  
areas of the city. This rather full provision seems  
curiously at odds with other more scant maternity and child



welfare facilities; the fear of providing too much help for the undeserving poor, present in other areas of the County Borough Councils' work, was absent here. There were no grants from the Board of Education for children under five, so despite the fact that classrooms were decorated and equipped largely through voluntary effort, this service was a cost to the Council without bringing in revenue. The same names, people who at other moments would have balked at such uses of the rates, were on the Board of Education, the NSPCC, and the Maternity and Child Welfare Committees; Alderman Phelps and Mrs Prichard make regular appearances in all these committees, with Mrs Morrell, (President of the Oxfordshire Nursing Federation) a frequent opener of school fetes and buildings. The explanation for this probably lies in the relative prosperity of the County Borough, the fall in the number of school aged children since schools were built in the last years of the nineteenth century which left empty classrooms, and most importantly the determination, ingenuity and inspiration of Miss Gee, head mistress of St Clements Infant School until 1936. She ran two full classes for two to five year olds, gave these children summer outdoor education on Angel Meadow beside the River Thames in a specially constructed shelter, gave them first aid attention herself, and encouraged the mothers in for rummage sales, outings, and meals. (13) Mrs Prichard was enlisted to open her summer outdoor shelter, in 1928. Miss Gee's nursery classes and open air school were visited by teachers from all over the region. Her expertise was enlisted by teachers in other parts of Oxford who wanted to convert their classrooms into nurseries.

Merthyr Tydfil had no money. (see above, Chapter One) Labour councillors were resistant to the professional classes telling their wives how to bring up children. The main facilities for two to five year olds here arranged and paid for through the Council were specialist medical ones;



orthopaedic clinics, artificial sunlight treatment, bottles of cod liver oil, and milk. For this, there was one clinic held once a fortnight for those children under five not attending elementary schools; the vast majority of three to five year olds did attend school.(14) As appeared above, general medical attention was available to the families of men insured through their Unions with a general practitioner.

There was a nursery school, opened in 1933 by the Viscountess Astor, that had been erected by the Save the Children Fund at a cost of £500 plus voluntary labour and equipment made by the unemployed. This nursery school, the first in Wales, had been fought for nationally, but it could not have been erected without the help of a local reformer (daughter of a public-spirited Minister) Mrs Margaret Gardner. The school was in a wooden hut in Dowlais.(19)

Oxfordshire had no nursery schools or classes of its own, although plenty of the villages admitted younger brothers or sisters to the classrooms.(20) Despite the government memoranda, there were no formal facilities for this age group provided by the Council.

As in every other area of care for the under five year old, local concerns and conditions seem to have been more important in determining policies and services than national ones. Tottenham's provision demonstrated its continuing desire to provide a comprehensive equitable health and welfare service for its population, expanding as the budget allowed, Oxfordshire its determination to keep the rates down, Merthyr Tydfil its continuing interest in finding loopholes in the law to feed its starving population, Oxford determinedly pursuing its own line on nursery education adapted to local circumstance. No locality examined here followed the national trends in a significant way; 'plucking

the slum mind out at its roots' seems as marginal at the end of the inter-war period as at the beginning in all these areas.

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## CHAPTER FIVE

### THE INFLUENCE OF PROFESSIONAL GROUPS AND INDIVIDUALS ON THE SHAPE OF INTER-WAR MATERNITY AND CHILD WELFARE SERVICES

#### The professionalisation of childcare.

During the inter-war years child and maternal health had become one of the preoccupations of government, and of the popular imagination. 'The old, bad days when every woman was supposed to know by instinct how to nurse, feed and teach children, have gone for ever. The art of looking after children is recognised as an art, if not a science.' (1)

The professions of obstetrics, paediatrics, specialist maternity and child welfare Medical Officers of Health, midwifery, health visiting, and nursery nursing blossomed in the inter-war climate. Numbers of these professional groups and the bodies that represented them testify to their growth and importance. At a national level the professional bodies were influential, helping form legislation and governmental policy. The College of Obstetricians and the Central Midwives Board both contributed to the 1936 Midwives Act, as discussed in Chapter Three. Jane Lewis argues how strongly these bodies furthered their own interests throughout this period. (2) However, in all the spheres of maternal and child welfare explored above, at a local level professional groups were matched by local political interest groups, whether the Co-operative women of Tottenham or the voluntary ladies of Oxford. Also, the more local the focus, the more important the personalities of the particular health visitor, MOH, or chair of the local voluntary association seems to become in shaping the services. When it came to the local application of national policies, professional groups had little power, but a strongly motivated and inspiring personality could exert considerable influence. This is true not just of professional bodies, but also the more 'political' groups - the Women's Co-

operative Guild, the Christian Socialist Union, the Women's organisations of the main political parties, the Women's Institutes - on examination, the local groups of these national bodies show distinct variation in policy and action, brushing aside the national issues communicated to them in favour of more pressing local ones.

The Influence of national professional groups in shaping local maternal and child welfare services

To begin with the fastest growing profession; by 1937 there were 5,350 health visitors, all of them women, employed by voluntary bodies and local authorities in England. Health visiting had developed as a profession, in the early years of the century, initially to safeguard maternal and infant health by home visiting. (3) Then as now health visiting could be rather an isolating occupation, poised between speaking for families and policing them. (4) Local authority health visitors had originally been engaged to visit the homes of mothers in their localities on the tenth day after birth, when the midwife's responsibilities stopped. It was understood, though seldom spelt out, that health visitors were for mothers in poorer neighbourhoods, not for women who had a general practitioner, a monthly nurse, and a nanny. The task of health visiting was often combined with TB visiting, mental deficiency visiting, school nursing, infant life protection, women's sanitary inspecting, and running any of the clinics connected with these functions. In Oxfordshire and Oxford health visitors were employed for all the above except sanitary inspecting and also for duties under the Blind Persons Act; in Merthyr Tydfil health visitors only did school nursing in addition to health visiting; in Tottenham their task was narrower still, including only health visiting and infant life protection, a statutory responsibility towards children fostered for reward.



Training regulations were continually changing and difficult to enforce on all but the new recruit. One reformer in Aberdeen was among the many who thought the skill of running a home was the most important requirement:

Tact ... good sense ... above average intelligence and general education ... the requirements ... that are wanted in a good housewife ... will equip a woman for house and family management, and for a place in the public administration of health schemes. (5)

In 1916 health visitors employed by Public Health Departments were expected to have two of the following: nurse training, the Midwives' Certificate of the Central Midwives Board, or the Womens' Sanitary Inspector's Certificate of the Royal Sanitary Institute. In 1925 a Ministry of Health Circular to Local Authorities encouraged recruits to obtain the new Health Visitor's Certificate of the Royal Sanitary Institute, and some Ministry of Health grants were made available for this purpose. After 1928, anyone recruited to local authority health visiting was expected to hold the new Health Visitor's Certificate. (6) During the 1920s and 30s, therefore, there was huge variation in knowledge and training among health visiting staff. In Oxfordshire in 1937 only six of the fourteen employed had the Health Visitors Certificate; in Oxford only five of eleven; in Tottenham fourteen of the fifteen, and Merthyr Tydfil four of the eight. (7) This mixture of qualifications among staff meant that a consistency of approach was unlikely, and rough and ready learning through experience the norm.

The situation was further complicated by the presence of volunteer health visitors, still present in Oxford until the mid 1920s, who worked without certification to advise mothers on cleanliness, childcare and midwifery. Miss Finucane, one of the earliest Oxford official health



visitors, remembers how this worked in practice. Every Monday morning the Senior Health Visitor Miss Jackson addressed a meeting of the volunteer and the official health visitors. There would be an exchange of information about difficult streets and cases; names of cases thought in need of special help would be handed on from the volunteers to officials.(8)

Because legal requirements were minimal, and local responses to the emotive issue of child health varied, practice was diverse. The 'experts' to whom the mothers turned might applaud one of several methods, depending on experience, place, year, mode of training or individual influence. The way they performed their tasks also depended on the number of their duties and the size of their practice.

Health visiting seems to have encouraged movement. In Tottenham, the curricula vitae of health visitor applicants show a mobile workforce, with movement up and down the country every two or three years.(9) Locally, these groups of women were not in a strong position to change things. Although they had a thriving national association, the Health Visitors Association (HVA), not all health visitors belonged to it, and while this body had some influence over national affairs at the Ministry, locally its influence was negligible.(10) The HVA twice attempted to intervene about wage scales in Oxfordshire. In April 1928 the Sanitary Inspectors and the Health Visitors Association wrote asking the Public Health Committee to support a resolution for a joint committee on health visitors' salaries, which was ignored. In 1929, the HVA sent a letter of protest to the Public Health Committee after an advertisement appeared for a health visiting post at under £200 p.a. In the event, the salary was raised, but not because of the letter. No suitable applicant came forward. the ones who wrote were either not cyclists or were too old, so they re-advertised

at the still very low, but slightly improved, rate of £200-250. This meant their revising present scales of existing staff:

the salaries of existing Health Visitors be increased by £50 per annum respectively thereby making a minimum salary of £200, rising by ... £10 [annually] to a maximum of £250. (11)

The difference between authorities can be emphasised by reference to health visitor scales in Tottenham during these years. In 1922 the Ministry of Health turned down a request from the Council to pay £220 p.a. By 1937, Tottenham paid £228 p.a., rising to a maximum of £360 p.a. (12)

Health visitors were in that most difficult position of trying to change the attitudes of individuals over strictly private family matters. They were expected to enter homes, criticise practice, and encourage new ways. They were the buffer between the Medical Officer or the clinic doctor, and the mothers and infants themselves. Miss Finucane, 93 years old at the time of interview in 1987, was employed with this brief in 1916/7 in the City of Oxford. The outpatients' Sick Baby Clinic wished for an infant nurse who would interpret the doctor's instructions for the mothers, and subsequently keep an eye on them in their homes. Miss Finucane, who came from a prosperous East London family, had trained and worked as an infant nurse in a London children's hospital. She remained in her Oxford job, which was her first, throughout her life, experiencing many changes in the definitions of a health visitor's tasks. She was virtually never 'off duty'. It was part of her job as a nurse to dress always for the part - hat, dark coat, lace up shoes - and to behave in a sober way in public. This included not going into public houses, and not being seen with a man, and not getting married unless prepared to give up work. This is how Miss Finucane remembers her duties at first:

I didn't do the weighing, we had people to do the weighing; I just gave the advice - feeding

mostly, diarrhoea, rashes, that kind of thing.  
And cleanliness: I had to tell them - they didn't want to bother with a bath - 'She had one the other week that'll do' kind of thing ... I must say they were inclined to breast feed ... but ... just when they thought they would ... That's what I had to get out of them, get them on the right road. Any old time would do, when they were crying.

You had to be careful about weaning. You couldn't always rely on them telling you the truth to be quite honest. That was the trouble, they would cover over, some went on 8 months to a year ... I advised about 6 months. Then dried milk was cleaner, safer - you couldn't always guarantee they did the right thing.

We had a clinic on a Friday morning [for nits]... school children not the little ones. The grandmothers would infect and reinfect ... they didn't mind, it was part and parcel of their life.(12)

Although on the surface Miss Finucane had an affection for the people she saw, there was an underlying exasperation, and a 'looking down'. This ambivalence shows in the following contrasts of attitude:

I can never remember anyone refusing me[entry].  
They were all wonderful. Because it was quite a new thing, you see; I was Oxford's first real one ... I enjoyed every minute of my work because of that. They were awfully good about coming to the infant clinics; that was quite new too you see....

In contrast she recalled how

some went to the clinics but some were not educated enough for that. They were quite characters - real characters ... I tried to teach them about vitamins but it was very difficult you see ... they had no idea. But ... their homes



were so unhelpful to them ... They had to go to  
the bottom to get water.

Miss Finucane had been so struck by the 'unhelpfulness' of people's homes that she took Dr Waters, who ran the Sick Baby Clinic, to see some of the mothers' homes on her day off. Tactfully, she took him to a Court where she knew there was a vacant home, rather than intruding on one of her families. She was determined to get Dr Waters to see the absurdity of his careful instructions to use boiled water and sterilised equipment in these circumstances.

Her relations with the volunteer health visitors described above were amicable. She remembers

They kept an eye for us and let us know  
They were always enquiring from us "was  
that alright what I did when I went to see Mrs  
X?" They were very helpful.

Clearly, the University wives who made up the bulk of the voluntary health visitors were well versed in tact.

I've quoted from Miss Finucane at length, because she gives a vivid impression of the attitudes and tasks of health visiting. The task of preaching new methods, and softening them to real family circumstance, was the same whatever route people took into their jobs. What was likely to change was the fashion promulgated - fat or thin babies, early or late weaning, this or that brand of baby food, infants sleeping with or away from mother.

Miss Finucane expressed above all the essential ambivalence of the task, which she summed up in this wry poem, (source unknown)

Good Morning Mrs Smudger  
Is Nellie in or out?  
There's just a little matter  
I've come to see about.  
We've had a head inspection

And doubtless you're aware  
That once again there's trouble  
Connected with her hair.  
I'll take her right away from school  
She shan't go there no more  
Perhaps you'll go on banging  
On someone else's door.  
I'm sick of scraping on her head  
With them there squasher chips  
It only makes her head ache  
And hurts my finger tips.  
I'll chop her blooming hair off nurse  
And see what that'll do  
She never had them till you come  
Its only thanks to you.  
Oh don't cry Mrs Smudger  
I'm sure you've done your best  
But then pediculosis  
Is such a horrid pest.  
Oh I'm sorry I was hasty nurse  
You never said twas that;  
I thought you meant them creeping things  
That crawls inside her hat.

The other profession that changed dramatically at this period was that of midwifery. Midwives held a curious place in the public imagination; they could exemplify traditional feared malpractice, or the most modern scientific image of safe delivery. These were strong images in a period where maternal mortality was all too real a fear. Figures for the midwives employed under the Midwives Act have already been discussed. There may well have been 'hidden' midwifery as well - the nursing associations in Oxfordshire villages were set up to stop the practice of neighbourly handywomen, which indicates that such people were still working in the neighbourhood. However, apart from isolated hearsay, there is little evidence of this.

The Central Midwives Board had extensive powers of regulation, and so did the Supervisor of Midwives employed by the Council and the Medical Officer of Health. Remarkably few midwives were ever disciplined, suspended, and none were struck off in these areas during the inter-war years. There are some instances of intervention. In Oxfordshire two or three midwives a year were suspended following infections - the connections between septicaemia, scarlet fever, and puerperal deaths were known. The CMB sent two circulars about disinfectant to local maternity and child welfare committees at the height of public concern over maternal mortality in 1930-31; they simply requested that the letters, the first about the necessity of Lysol and the second 'the strength of Lysol to be used and the methods of sterilisation to be employed, be circulated to all Oxfordshire midwives.(13) Nationally, Lysol was under scrutiny. London County Council entered into a correspondence in the Medical Officer in the spring of 1930 which threw doubt on the efficacy of Lysol as a bactericide. This debate ended with the Central Midwives Board conceding that Lysol should not be used as an antiseptic.(14)

Merthyr had its own federation of independent midwives; a testament, probably, to the radical political traditions of the area, and the strong union and Independent Labour Party voice. However, its scattered deputations to the Public Health Committee did little to influence events; in 1931 a deputation argued successfully for compensation where they lost trade owing to Council ante-natal work, compensation that was in line with recommendations from the Ministry of Health, whereas in 1934, and 1935, when they asked for compensation in respect of necessitous cases sent to the Poor Law Infirmary, they were refused.(15)

In the period prior to the Midwives Act of 1936, the Ministry of Health offered a variety of inducements to improve practice. They offered (through local authorities)



to reimburse practising independent midwives when they were suspended after being in contact with any infection that might lead to puerperal sepsis or fever, and to reimburse in some measure for any cases brought to ante-natal clinics which led to a loss of business if complications were found. At the time of the Midwives Act, the government recommended a salary for midwives, whether they were salaried staff of the Public Health Department or 'licensed' and paid through voluntary organisations or independently. Despite the presence of the Federation in Merthyr Tydfil, the wages offered - and accepted - by the independent midwives, who all agreed to convert to Council employees in 1937, was £50 less annually than the nationally recommended minimum; £150 rising to £200, rather than £200 rising to £250. The Medical Officer of Health, T H Stephens, explicitly states

It seems quite unlikely that any midwife in an area such as this, who has the opportunity of municipal service, will take on independent practice. (16)

Under the Midwives Act, midwives who no longer practised adequately through age or infirmity were pensioned off, compensated with grants from the Ministry by the local authorities. In each area, several midwives were 'pensioned off' in this way in the late 1930s, apparently without demur. The number of practising midwives fell in each of the areas here, partly connected with the fall in the number of births, but also because the midwives who had delivered only a handful of babies a year ceased to practice. This is discussed by Sarah Robinson in her 1990 article 'Maintaining the Independence of Midwives'. (17)

#### The Influence of Unions and Professional Groups

Among the four areas, Tottenham had the largest number of professionals in the Health Visitors Association, and in the National Association of Local Government Employees (NALGO).

Mrs J Kent Parsons was a prominent national figure in the HVA. Her health visitors were members of the Association, unusual among local authorities for the large membership; in 1923-4, all twelve of the health visitors appear as members, compared to Oxfordshire, with only one health visitor member, and Oxford which had none. (18) Dr Kirkhope himself was involved, serving as national vice-president of the Association in 1935. Dr D Kirkhope, the Medical Officer of Health for Tottenham 1913-1937, was the Chairman of the local NALGO branch for several years. It is certainly true that wages were higher in Tottenham than elsewhere, but how much this was London pressure or the ambience of the Co-operative Labour Party, and how much internal Union pressure, it is hard to gauge. It was not deputations from NALGO or the HVA that instigated the wage rises, but deputations from the County Borough Council itself. It seems more likely that it was the the local political climate that led to the large group membership as well as the comparatively large wages and fair conditions.

Each locality had its own particularly strong pressure group which made a stand at some time during the inter-war years. Oxford pharmacists made an attempt to take over the cod liver oil, Virol and vitamin market in 1936; the compromise that was reached, well in line with Oxford's general liberal philosophy, was that a note should be displayed in all the Centres telling mothers that if the family income was £250 or more a year, they should buy all preparations at market price through their chemist. Dried milk, malt and oil, and cod liver oil were all available from the centres to those with incomes under £250. Those on this income - seen as unemployment level and below - could also get a 'prescription' from the Medical Officer for vitamins from the chemist, and milk from the dairies. In 1937, when the pharmacists applied to extend this scheme, they were turned down. (19) Oxfordshire general practitioners held some sway.



In 1921, when the Radcliffe Infirmary backed by the Ministry of Health was looking for a grant from the Council for their Maternity Home, the Council refused until pressure was put on them from a deputation of eighteen local general practitioners. (20) The Oxfordshire Nursing Federation, a voluntary body, probably held the strongest influence. It was to the executive committee of this body and not the Public Health Committee that the Oxfordshire Branch of the British Medical Association sent a deputation in 1925, complaining that nurses 'had overstepped in connection with cases of fracture, rashes, pneumonia ... [and that] with regard to Midwifery, that the nurses were encroaching on their work'. The meeting arrived at a compromise. The nurses agreed not to 'use their influence to get a case when the patient has already engaged a doctor'. (21) The president of the ONF, Mrs Emily Morrell, was co-opted onto the Public Health Committee in 1919. Although the Council often prevailed, after the Midwives Act of 1936 a strong mutual dependency existed between the ONF and the maternity and child welfare service, with the Council paying for the majority of the ONF district nurse-midwives' salaries. After World War I, they argued unsuccessfully to carry out the Council's school health visiting, but successfully to take over the Council's midwifery. In this last, they merely lined up with strong pressure from the Ministry, which was reluctant to continue subsidising a state service where a willing voluntary one existed. (22) The strength of the ONF as a pressure group is possibly best signalled by the proposed Ministry intervention to resolve differences between the ONF and the Council in 1930. (23)

#### Individual Contributions to the Shape of Services

Maternity and child welfare was a subject of national concern in the inter-war period, and as such attracted outstanding individuals committed to their work, who had high public profiles. This was true nationally and locally,



in the state and the voluntary sphere. In terms of national public profile, the Tottenham Medical Officers of Health, Dr D Kirkhope and Dr G Hamilton Hogben, were the most prominent. Mrs J Kent Parsons (MBE) and Mrs F Pearse (MBE), Superintendent Health Visitors for Tottenham and Oxfordshire, were outstanding locally, as were the Liberal Councillors and members of voluntary committees Mrs Edmunds of Merthyr Tydfil, Mrs Prichard of Oxford, and the voluntary society members Mrs Morrell (Oxfordshire Nursing Federation), Mrs Wells, Mrs Smith and Mrs Prichard. They, and their less prominent colleagues, undoubtedly contributed to the shape their local services acquired. However it is probable that their influence was dependent on many other local factors at play, and that each one of these individuals operating in another locality would not have achieved the same service.

In Oxford, Dr A Ormerod had been the Medical Officer of Health since 1902. He retired from this post in 1929 after a long and energetic career. He had been a familiar figure in the drawing rooms of Mrs Wells and Mrs Prichard, a friend of Alderman Phelps the Chairman of the Charity Organisation Society and of the Board of Guardians, and shared a house with his life long companion Dr Waters who ran the Radcliffe Infirmary Sick Baby Clinic. Dr Ormerod was particularly interested in school health and Maternity and child health, and a long standing active supporter of the Infant Welfare Association. Dr G C Williams, his successor, was a scholarly person, well respected by general practitioners in Oxford. He had worked as Dr Ormerod's deputy since 1921. Immediately he succeeded as Medical Officer of Health in 1930 he began to work for change in the maternity and infant welfare field, bringing a more professional approach to the field, and loosening the hold of the voluntary association, while acceding to some of their demands. It is likely that some of the following

changes had been in his mind for a decade; the appointment of an assistant woman Medical Officer of Health to help mothers, finally accomplished in 1933 had been suggested by the Oxford Health and Housing Association in 1918-19: the volunteers 'Have expressed repeatedly in various ways their conviction that the City would do well to make the appointment of a lady as assistant Medical Officer of Health a permanent feature of its health staff'. (24) The Interim Report on Maternal Mortality issued by the Ministry of Health in 1929 was used by Dr Williams in 1930 to argue for a comprehensive set of reforms to bring the skills of general practitioners into all spheres of maternity and child welfare. He recommended ante-natal centres run by medical practitioners, and skilled obstetric help for emergencies, preferably given by general practitioners. To strengthen his case, Dr Williams had enlisted the help of the city's general practitioners. Dr Mary Radford prepared a survey of the current facilities, showing their inadequacies. He was successful in his bid for these expensive facilities, after a skilfully handled committee meeting. (25) However, his hand had been strengthened by some criticism received from the Ministry of Health about the lack of medical expertise in Oxford's maternity and child welfare services, and also a current campaign by Headington residents who were resisting the downgrading of their own infant welfare clinic which had its own general practitioner which, it was threatened, would be removed since Headington had come inside the City boundaries under the 1929 Local Government Act. (26) This change, although expensive, was still in line with the Oxford philosophy of prevention, not treatment. The medical practitioner's role at the clinics was to monitor and advise. Medical treatment and the costs of medical treatment were still the responsibility of the mothers themselves.



In Oxfordshire, the Medical Officers of Health were Dr C Coles, until 1932, when he retired aged sixty-five, succeeded by Dr H Jennings. Dr Coles was characterised in the Public Health Survey of Oxfordshire in 1931 as 'notoriously slack', more interested in growing roses than in public health. It was said

The maternity and child welfare department is run almost entirely by Mrs Pearse, the senior health visitor. I was favourably impressed with her ability and discretion; she is a qualified nurse with a C.M.B. certificate, and a doctor's widow of perhaps rather better education and wider outlook than many health visitors. Her records, according to Miss Colles, are a little confused, but her work is conscientious, and the personal interest and spirit of devotion which she shows in all matters pertaining to child welfare is reflected throughout the whole department.

Dr. Coles leaves M&CW[sic] work entirely to her, but is obliged to attend the committee meetings[quarterly] himself. This is probably a disadvantage and Mrs Pearse fears that her recommendations are sometimes not stressed with proper emphasis or even fully explained. (27)

Dr Jennings was a brisk and active Medical Officer of Health. He came from Lincolnshire, already on the national Health and Cleanliness Council and interested in tuberculosis work. His first actions in Oxfordshire were to ask for a telephone and better clerical assistance, and he went on to try to reclaim more of the doctor's fees where the doctor had been called in by a midwife in an emergency. This last endeared him to the Council, although it did nothing to increase the money claimed back. He went on to complain that the 'sterile outfit' lent by the County in necessitous cases was in no sense sterile, and had to be



replaced. After this beginning, however, maternal and child welfare services went on much as before. Outside the council, Mrs Morrell, and her colleagues Miss Ashurst and Lady Mason made the Oxfordshire Nursing Federation into a powerful public body providing an umbrella organisation for around sixty village nursing associations. Mrs Morrell was the wife of a wealthy Oxfordshire brewer, and was active in the Primrose League. Miss Ashurst was the daughter of Mr J Ashurst, Chairman of Oxfordshire County Council, and of the Oxfordshire Rural Community Council for most of the inter-war period. Lady Mason's daughter-in-law set up a private infant welfare clinic based on Truby King's work called the Mothercraft Clinic in Summertown, North Oxford, in the last years of the 1930s. They were powerful personalities, but without the Council's nurturing of the independent sector, would not have been as influential as they were. (28)

Tottenham Councillors were for the most part tradespeople. Councillors M Timms and T Elderfield were both of the Brotherhood Movement; for many years Councillor Elderfield, a butcher, was connected with the Young Men's Bible Class, and Councillor Timms worked with orphan children through Methodism. Mrs W Kent and Mrs A Kitchener were both members of the Women's Co-operative Guild, and had entered local government through this route. Dr Kirkhope was a 'man of strong principle and devotion to duty',

one of the outstanding medical officers of health in the period which has seen the birth of the school medical and maternity and child welfare services and the advancement of the public health department to a primary place in local government affairs. (29)

He was a barrister and a medical man, educated in Belfast and in Glasgow, Cambridge and Grays Inn and the Middle Temple. He was an orator, a writer, an organiser, and a man devoted to his staff and to the ideal of preventive public

health services. He was in his private life a musician, and a member of the Catholic Apostolic Church, a small messianic sect formed in the nineteenth century by a group that broke away from the Church of Scotland. He sang with Mrs Kent Parsons, the Senior Health Visitor for the whole inter-war period, who took up her post in 1911. She was on the committee of NALGO, the chairman of the Women's Public Health Officers' Association, and a member of the National Council for Maternity and Child Welfare, the National Council of Women, and the Health Visitors Association. Dr Hamilton Hogben, who succeeded Dr Kirkhope in 1937, was also dedicated to public health and preventive medicine. He was educated in Tottenham schools, and then in London University, spending five years as a General Practitioner before becoming a Medical Officer of Health. He was awarded the Norah March trophy for pioneer work in maternity and child welfare during his time as Tottenham's Medical Officer of Health, from 1937-65. In Tottenham's records, the strong personalities of these people shine through meeting after meeting. In particular, Dr Kirkhope's fiery inventiveness, and invective against the Ministry of Health, enliven all the proceedings. In the early 1920s, the Ministry attempted to renege on their agreement to fund 50% of the milk bill for Tottenham. Dr Kirkhope, with the backing of the Council, fought back, enlisting the help of the Trades Council, and within four months the Ministry gave way. (30) In July 1922, Dr Kirkhope suggested the following reply to the Ministry letter complaining that Tottenham made too little use of volunteers:

Repeated efforts have been made to enlist the assistance of voluntary workers. At one time it appeared that the disbanded VAD nurses would afford some assistance, but when they realised they would not be independent negotiations terminated. The Committee would welcome voluntary co-operation, such as the Ministry suggests.



Tottenham, however, consists of two classes of people, those who cannot afford to give voluntary service and those who will not. (Draft letter to the Minister, 1922) (31)

For all Dr Kirkhope's inventiveness, he needed the help of his committees to bring his schemes to fruition.

Merthyr Tydfil's two Medical Officers, Dr A Duncan until 1933, and Dr T H Stephens from 1934, did little to shape their public health services. They responded as best they could with inadequate budgets to Ministry complaint about their services. With the help of the women Assistant Medical Officers for Maternity and Child Welfare, Dr Eppynt Phillips until 1929, Dr Griffiths until 1933, and Dr Esther P. Jones from 1934, they created an orthopaedic service, an active ante-natal service, a clinic for artificial sunlight treatment. They also helped to get as much material help into the borough as possible, through voluntary and statutory channels, milk and cod liver oil through the Council purse. Here again they were working within the philosophy of the Council, which wished to provide as much help as possible with as few strings attached as the Ministry would accept. When he was first appointed, Dr Stephens wrote a detailed paper with proposals for changes in the obstetric services some of which were accepted. (32) However they were accepted in the context of severe criticism of Merthyr's facilities from the Ministry, so changes were necessary anyway to secure the grant.

### Conclusions

Local personalities and groups take their place with economics, geography, politics and culture to create the particular set of services on offer to the families who it was hoped would use them. The only thing a mother would know for certain when she moved town, at least between these four areas, was that even if things were called the same



thing, they rarely delivered the same service; and whatever income guaranteed free service where she had come from would be unlikely to secure the same service free where she was going. She could also be confident that the pressure groups that shaped services in one locality would have a different profile in other areas.

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## CHAPTER SIX

### THE COSTS OF MODERN MOTHERHOOD TO LOW INCOME FAMILIES IN INTERWAR BRITAIN

each child under two should have one pint of milk a day, and a teaspoonful of Cod Liver Oil three times a day except in hot weather. If this cannot be afforded the doctor at the local Infant Welfare Clinic will see that it is provided free.(1)

This piece of advice, from 'Food Budgets for the Family', (1932), Leaflet No 41 of the Association of Maternity and Child Welfare Centres, with examples for families 'on a minimum income', was one of the thousands of prescriptions for modern motherhood aimed at poor mothers in the 1920s and 1930s. The author of leaflet No. 41 was confident that, although the advice would cost money to follow, where necessary the state (the local authority) would provide for what were then called 'necessitous cases'. Evidence discussed below suggests the author's confidence was misplaced. Mothers who wished to follow the advice had no guarantee that the state would provide if they could not meet the expense. Services and treatment nationally prescribed were not always available locally. Where they were provided, sometimes free to the necessitous, the maze of standards and procedures, different scales of assessment and methods of calculating net family income could bar applicants, leaving them to shoulder the guilt of a sickly baby, or go without some necessity themselves.

In the commercial world of the inter-war period, new fashions in motherhood and infancy offered new and promising market possibilities. Medical, dietary, and general prescriptions for healthy childhoods were disseminated by experts who found an easy target amongst families concerned

for their children's welfare. The numbers of nurses and consultants involved as specialists in child rearing and maternity care expanded, (see Chapter Five above) and the incomes and consulting rooms of general practitioners were swelled by pregnant mothers and their infants.(2) Hospital delivery as we have seen became increasingly common in these years; the percentage of women having their babies in maternity wards rose from 15% in 1927 to 25% in 1937, and 54% in 1946.(3) Increasingly, the cheaper domiciliary midwife was advised only for 'safe' and 'normal' deliveries.(4) Numbers of infant welfare clinics in England and Wales increased from 842 in 1916 to 3,145 in 1937, in which year there were 5,350 health visitors in Britain, a large part of whose work was to give child rearing advice in the home.(5)

#### Modern methods of child rearing: the cost to the family

Both at the time and subsequently, substantial claims have been made for the success of the maternity and child welfare movement in Britain, although others have challenged the legitimacy of the claims.(6) Less prominence has been given to the question of the cost of these services to low income families who followed the advice provided. Jane Lewis and John Macnicol discuss the reasons why economic aid was not given to mothers in this period, including an avoidance of the minimum wage issue, and a concentration on the growth of professional bodies rather than the duties of the State towards mothers and children. The Women's Co-operative Guild and the Children's Minimum Council were amongst the most prominent bodies promoting family allowances (state grants to aid poor families rear their children) before World War II.(7) This section looks at how much the advice and admonition on child rearing pouring from all quarters to poor mothers eroded the meagre budgets of low income households, as they spent the money instead on the

prescribed cots, prams, layettes, proprietary foods, and hospital deliveries.

One significant outcome of the maternal and child welfare movement as it developed in Britain was the promotion of a viable commercial market in medical services, patent foods, infant clothing and nursery equipment. Health visitors, medical officers, and volunteers in infant clinics distributed advice on pregnancy and childrearing in urban working class districts and in villages, substantially the same advice as that given to women in middle-class districts by general practitioners and nannies or nursery nurses. These centres were primarily educational in their aim. As a British Medical Association pamphlet of 1921 argued,

These centres are used in three ways:- (a) for educational, advisory, and preventive work; (b) for treatment of actual disease in infants; (c) for the provision of food and clothing or other material goods when necessary or desirable.

Nonetheless the Association went on to claim that:

Nearly all the witnesses agreed that it was detrimental to the interests of the work to encourage the opinion that the Centre is a place to bring babies when they are ill ... [and] the gratuitous supply of artificial food and dried milk has proved detrimental to the best interests and influence of the Centres. The people who go to them mainly for what they can get very cheaply or for nothing are not as a rule the kind of people who value or will benefit from the educational work of the Centre. (8)

By becoming committee members and volunteer health visitors in districts and clinics, middle-class mothers who were converts to the new ideas, sometimes spread modern motherhood amongst labouring and working-class women in town and countryside. Then, as now, fashions in what was



good for a baby, or what promoted good health, were liable to change; faith in chocolate and cocoa in the years in and after World War I gave way to a belief in the health giving properties of milk and butter in the later 1930s. Each succeeding fashion had its advocates. Most advice cost money to follow. Advisers were aware of this, and numerous ways were devised of reducing the expense for low income families. In many clinics patterns and material for the prescribed 'layettes' were sold at cost price. Parents were encouraged to make cots from orange boxes, whilst patent foods and medicines were bought in bulk and distributed at cost price.(9) Special grants were available to low income families through which local authorities provided services free to those in need. The Ministry of Health would reimburse local councils up to 50% of costs incurred in this way. The policy of only giving services and goods free to those who 'needed' help created an administrative nightmare, and a system of grants that was very uneven. As Titmus argued,

Before the war, it was often believed by many people who did not use the statutory health services that provision was free of charge. This was not so; for local authorities had the power (and sometimes the duty) to recover what they could from the people who were helped. In consequence, there grew up a bewildering variety of means tests covering a large range of services. Apart from unemployment and health insurance, at least twenty tests were in common use by the local authorities. Nearly all these tests were based on different income scales, and often the same authority employed for no good reason different tests for the various services it supplied.(10)

Clearly, if these means tested grants helped the people who needed them, they would have ameliorated the problems; if appropriate grants had been readily available, low income

families would have been put to no extra expense by the modern methods, and not inconvenienced by them. However, a popular image of the respectable working-class family in the inter-war period scrimping and saving to pay for what experts told them would promote their children's health, suggests new methods became a significant item on family budgets.

Eve Garnett explored this theme in a children's book written about a small town dustman's family of the 1930s. The book met with much acclaim when it was first published in 1937, and its sequel was equally popular when it appeared in 1956 in the midst of great enthusiasm for the newly created National Health Service. Both books were based on notes and real memories of the minutiae of East End life in 1930's London. In the book, the Council paid for the children's stay in isolation hospital with scarlet fever, but the convalescent holiday and the strengthening medicine for the children both had to be paid for out of the family income, causing real hardship, as testified in the following conversation between the parents. Mrs Ruggles said:

You'd best realise its savin' up for  
doctors' and chemists' bills we've got to be afore we  
thinks of anything else. Peg and Jo's got to be fed up  
with malt-and-oil when they comes out, and Jo's  
that pulled down the doctor says as six  
weeks in the country'll barely set him up'

And later, as Mr Ruggles worked out the costs of  
convalescence, he commented:-

Four Pounds, nine shillings, and sixpence, Rosie' he  
announced to his wife at last, 'just for the fares  
and keep.

Finally, when the twelve year old daughter Kate dropped the  
malt-and-oil:-

Oh, how dreadful! The precious malt-and-oil - an extra  
large jar too, to last all the holiday - a whole



8s.6d. worth ! What would Mum say? And what would Peg and Jo do without it? - probably get ill - get measles again - perhaps die this time - a second attack so soon! (11)

A social survey carried out in the 1940s on the real costs of maternity outlined the other hidden costs in addition to the midwifery fees. The survey team concluded that the average working-class family of their sample (all the babies born in one week during the spring of 1946) spent around £32 on each first baby, whilst agricultural families spent £22. This included money on equipment, clothes and housework, which could not be covered by the 30-40s. National Insurance grant paid to those families with a parent in work. Although costs might have risen in a decade, and expectations may have risen, most items in the following list bought by the 1946 mothers were those urged on the mothers of the 1930s: 'Pram, cot, bath, blankets, rubber sheets, napkins (at least 26), vests, nightgowns, dresses, knickers, matinee coats, bootees, leggings, gloves, bonnets, and shawls. (12) This was merely the original outlay for a straightforward birth. Complications could increase the expense and so could infant ill health. Added to this was the cost of food and medicines advised to safeguard the infant's health.

Infant clinics and health visitors were key promoters of new ideas, but these were not the only sources of changing ideas on childrearing practices. Mothers were exposed to advice on modern child rearing from a variety of other national and local sources. National and local newspapers and women's magazines carried advice columns on child rearing; advertising hoardings urged patent products to safeguard children's health; there were health programmes on the radio; special child rearing books and magazines were produced, with wide circulation and multiple printing; for instance, The Mothercraft Manual (1st edition 1923) had sold over 263,000 copies by 1948, and was in its 11th



edition. (13)

Modern methods were in the air. An Oxford informant, who disliked the infant clinic as being unhygienic, and was suspicious of health visitors as 'do-gooders', remembers magazine articles on children being passed from hand to hand in her street. The local chemist answered her queries, not the health visitor. For all that, this informant was modern in her methods; with an income of under 30s. a week (her husband was a milkman) she contrived a pram, a cot, patent foods, and visits to the general practitioner. The child rearing advice carried with it a threat. Ignore it and jeopardise your family's health; follow modern methods and win peace of mind. This same informant still blames herself for the fact that one of her children was frail and suffered from colic, which she linked to the fact that she had failed to continue to take pills recommended by the doctor at the ante-natal clinic. The pills had been recommended because the medical officer had thought she was lacking in calcium. She had been given a 'paper - not a proper prescription' to go up to Timothy Whites the Chemists. She'd taken the pills until they ran out, and then had not been able to afford more. (14)

#### Poverty: the national and the local problem

The expense involved in following advice, and effects this had on the budgets of low income families, varied from area to area. Wages, rents, and levels of unemployment varied considerably, and relative costs need to be set in their local context, and are discussed below. However, there is abundant national evidence that many families in the 1930s survived on poor levels of nutrition, and that those families with young children were particularly at risk. These families, who found it hard or impossible to buy adequate clothing, would have difficulty meeting another demand on the family purse. In detailed research on family budgets M'Gonigle and Kirby, Boyd Orr, and Fraser

Brockington all show many families which did not have enough money to maintain protein levels necessary to maintain health. (15) In 1936 Boyd Orr estimated that

so far as the evidence goes, it suggests that people living at the economic level of the dole are living near or below the threshold of adequate nutrition. The number at this economic level must run to nearly 20% of the population, somewhere in the neighbourhood of ten millions. (16)

In 1938 Pringle similarly claimed that it was the lack of money available to housewives rather than bad household management that caused nutritional problems in families. According to a key study by Fraser Brockington, large families with very young children were particularly at risk of falling below the adequate nutritional standards. (17)

As the nutritional surveyors found, local, rather than national, surveys of families themselves in their own districts were the best way of establishing what was happening. To rehearse some of the differences between the four areas studied here, particularly economic differences: Oxford, a prosperous University town; Oxfordshire, a large county with a scattered population; Tottenham, a borough on the boundary of greater London; and Merthyr Tydfil, a sprawling town in the depressed South Wales mining valleys. There were many contrasts. Oxford City experienced five per hundred unemployed at the worst through the inter-war period, and Merthyr Tydfil at the other end of the scale experiencing unemployment at sixty out of a hundred. The Tables in Chapter One show the census material for general population, the birthrate and numbers of infants under four years old, for 1921 and 1931. J Boyd Orr, one of the nutritionists cited above, told an Oxford audience in 1939 that a family of five could not be adequately nourished on less than 20/6d spent on food per week. (18) Oxford is the most prosperous area represented here. It seldom saw



unemployment of more than 5%, and many workers brought home wages of between £2 and £4 per week. Moreover overheads were high; rents could be up to 20s. a week, with travel, heating and insurance in addition. As workers flooded into Oxford in the 1930s, overcrowding and homelessness became a real problem, and landlords could charge high rents. Even here, a young family of five relying on one income could slip below the malnutrition threshold. In Merthyr Tydfil, where over 50% of the population were unemployed through most of the 1930s, and the majority of household incomes were 29s.6d. or less, most families would have been routinely malnourished on Boyd Orr's scale. Those Oxfordshire village housewives whose husbands were agricultural workers earning between 32s. and 37s. on average must have smiled at the stall in a travelling Women's Institute Exhibition in 1934, showing how to cook wisely for a family of five with only 20s.3d. to spend on food.(19) Tottenham families, with high London wages, might have been expected to be more prosperous. However, Llewellyn Smith found 7.8% of Tottenham's population living in poverty in his 1932 research for the New London Survey.(20)

The local evidence presented here bears out the national claims that many families must have been malnourished, and could have ill afforded extra claims on the household budget; the need for grants and free services was evident.

Local variations in 'scales of eligibility' for free maternity and infant welfare provision .

Voluntary groups coping with need across Britain were keenly aware of the problems of poverty and its effects on child health in the 1930s, and the need for grants and free services. In 1932, the Save the Children Fund carried out a survey of local authority and charitable help given to families with babies and young children.(21) The survey was



of nineteen towns; Table 6.1, taken from this survey, shows the variations in provision which existed, even between three neighbouring authorities in South Wales. The question as to whether these variations were caused by variation in real need in the different towns has to be asked, but a comparison of the unemployment figures in these towns suggests that 'need' would have been fairly constant. Despite this parity, it was the town with the least unemployment that provided citizens with most hope of free milk and food.

Throughout Britain, local authority help for families in need varied greatly. Miss Burt, of the Midwives Board, carried out detailed research in the late 1930s under the auspices of the Population Investigation Committee, which uncovered wide variation in scales of eligibility for midwifery, foods and treatment for mothers and infants. The research, not published until 1943, showed that families could not rely on free services being available. Some of the blame for this was laid on the government. For midwifery,

In necessitous cases they may, but are not required to, remit part or the whole of the fee.

There is no definition of 'necessitousness', and the Ministry of Health has, so far as we know, given no guidance on this point. (22)

In 1939, Ford, a social researcher from Southampton University, published his Incomes, Means Tests and Personal Responsibility, in which he exposed the enormous variations which existed across Britain. His book was a plea for standardisation and co-ordination in the offering of free services. He found authorities offering eleven or more services free on seven different scales for calculating need. These scales might include the income of head of the family alone, or all the household; they might make allowances for rent, travel, meals at work, or none of these things; they might be based on a simple rate per capita, or

on a local sliding scale; they bear the marks of 'having been drawn up at different dates, and under different circumstances of financial ease and public mood.' (23) The legislation covering scales of eligibility was permissive; each local authority negotiated each scale for each service separately, as the occasion arose, with the Ministry of Health. The Ministry of Health offered suggestions to local authorities about what services should be offered and about the scales of eligibility for services. These were also drawn up at different times, in varying financial circumstances. Authorities were issued guidelines suggesting a generous scale of eligibility for free milk before 1922 and in the later 1930s. Circular 1519, dated 1 April 1937, urged the supply of free milk and food as a preventive health measure. During the depression, guidelines were more stringent. The only constant message from the Ministry was that, wherever possible, authorities should 'pay special regard.. "as to whether particular services were or were not likely to be remunerative, either at once or in the near future"'; not a very hopeful note for families in need. (24)

#### Services and scales of Eligibility in

#### Tottenham, Oxford, Oxfordshire, and Merthyr Tydfil

Experiences in the four localities of Merthyr Tydfil, Oxford, Tottenham, and Oxfordshire show in more detail the considerable variation of service and material help offered by the state, through local authorities, and by charitable agencies. (See Chapters One to Five above.) These four areas all had their share of low income families, as described in previous chapters. However, there were many contrasts. There were interesting political and cultural contrasts, explored below, but first I want to outline the services offered to mothers and children and the scales of eligibility which existed for low income families wanting their services free. Councils provided advice free through



medical officers, health visitors, and clinics. Some advice cost nothing to follow, but where the advice was to seek medical treatment, follow a diet, or take simple remedies the family paid, unless they applied for help and could prove eligibility. The only service which the councils paid for first, and reclaimed afterwards, was where general practitioners were called in for medical emergencies during domiciliary midwifery cases. This procedure was a statutory one which raised grumbles; all authorities discussed here found it hard to reclaim, and some reclaimed from as few as ten per hundred of cases.

Of the four Councils discussed here, the one offering the most services, and the most generous scales, in maternity and child welfare, was Tottenham. A borough with a strong Co-operative Labour presence and a dwindling charitable middle class through the inter-war period, which escaped the worst of the depression, Tottenham's maternity and child welfare provision and school health services (all public, none voluntary) were the crown of civic pride. In 1920, there were four infant clinics, a minor ailments clinic, an eye clinic, an orthopaedic clinic, a dental clinic, two ante-natal clinics, a cot centre (residential nursery) and a day nursery. Mothers could be prescribed meals, milk (1½ pints per day for expectant mothers and children under five), hospital delivery, home helps, or convalescence for themselves or their children. All advice was free; all treatment, care, or goods could be obtained free including milk, Virol, and cod liver oil and malt. In addition, many goods were available at cost price through the clinics, including paper patterns and materials for layettes and infant clothing. By 1937, midwifery, obstetric care, a gynaecological clinic which also gave birth control advice, nursery schooling and infant hospital treatment had been added to the list of local authority facilities. The maternity and child welfare services were well advertised.



There were elaborate health weeks each year, with competitions, talks and posters. Access was easy. Clinics were open every day except Sunday in one part or another of this geographically compact borough; health visitors routinely asked the Maternity and Child Welfare (M&CW) Committee for free or reduced rate items for mothers, which the committee allowed at its monthly meetings.

The 1919-20 scale of eligibility for free milk was 7s.6d. per head income where there were five in the family, parents and children under fourteen. If the family of five could show that only 37s.6d. came into the household each week, they were eligible for free services. The actual incoming cash could be more than this, because several discounts were allowed. The following factors were taken into account to arrive at the sum. Only 50% of income of lodgers and children over fourteen, after discounting the first 12s. was seen as household 'income', and rent, insurance, fares to and from work, and care of the children could be deducted. (25) This could mean that a family on a respectable wage of nearly three pounds a week could be eligible for several pounds worth of help.

In 1921 the Ministry forced Tottenham to tighten its scale. (26) Rent and insurance only could be deducted. Although the stated level was still 37s.6d. for a family of five, the real level of eligibility dropped - a family needed to be poorer to qualify. There was a good take up of the free milk. There were 3-400 recipients a week in the 1930s and an expenditure of £3-4,000 per annum. Compare this with Merthyr Tydfil's expenditure on milk described above of £2,935 in 1931. Tottenham's scale for free midwifery, agreed with the Ministry in 1937, was different from its milk scale; income 12s. per head for a family of five, 60s., less rent only, and counting one quarter of the State maternity benefit as income. (27) The cost of the day

nursery in 1928 was 'minimum 6d., increases 1d. for every 1/- above 10/- of weekly income, less rent.' (27) Even where access to free services was encouraged, as it was in Tottenham, the system was extremely complicated, and eligibility for one service did not guarantee eligibility for another.

Where advice had been given and was not taken, in Tottenham, parents could find themselves chased up and threatened by the National Society for the Prevention of Cruelty for Children (NSPCC). In 1938, in Tottenham's School Medical Officer of Health Report, the NSPCC was praised for 'ensuring treatment and cleanliness in those cases where parents fail to act on the advice given by members of the school medical staff'. The NSPCC increasingly took on a new role in the 1930s, of following up and legally threatening families who did not follow the clinics health prescriptions. (28)

Since Merthyr Tydfil County Borough Council was Labour dominated through much of the inter-war period, it might have been expected to have the same level of service, and the same ease of access to free service, as Tottenham. However, its maternity and child welfare service was restricted in comparison. In 1920 there were four infant clinics (up to four miles walk for a mother and her baby to attend) and a minor ailments clinic; by 1937 there were, in addition to the above, a dental clinic, orthopaedic clinics, a maternity wing of the local authority hospital, borough midwives, an artificial sunlight clinic and antenatal clinics, and cod liver oil was available free on production of an unemployment card, as was milk (1 pt per day for an infant under 1 yr and expectant mothers in the last 2 months of pregnancy). (29) The scales in force to claim free milk for mother or child in a family of five on 2 July 1937 were 7s. per head net income after deduction of rent (35s.). The scales for free midwifery agreed the week before on 29 June



1937 were 10s. per head net income- (including the unborn) after deduction of rent, or 50s. for a family of five. Midwifery cost 25s. in 1937. Having a baby in the Infirmary cost 42s., but costs could be considerably higher if there were complications. Nellie Brown on the 28th of June 1927, was allowed to pay off her bill of £30.8s. in 2/- monthly instalments to the Council. (30) The application procedure for obtaining free milk was so simple that it drew Ministry complaint; a mother had only to show her husband's unemployment card at the clinic to obtain free milk for herself in the last two months of pregnancy, and her infant up to one year.

Merthyr Tydfil, as a nationally designated depressed area, drew some charitable help which effectively increased goods and services available. The nursery school mentioned in Chapter Five offered places at 1/- a week, the National Birthday Fund provided Marmite, Ovaltine, and Colactol free through the clinics for the years 1934-7, and Pearsons Fresh Air Fund and the Eastbourne Round Table provided some free holidays. However, the charitable sources were sporadic 'windfalls' for poverty-stricken families, available one year and not the next.

Merthyr Tydfil and Tottenham had Labour Councils; Oxford and Oxfordshire Councils were both dominated by Liberals and Conservatives. In Oxfordshire, the scales for free milk dropped in 1932 from 30s. income for a family of five (no stated allowances could be taken into account) to 29s. , with allowances for rent. This represented a considerably more generous scale in reality, since agricultural workers often paid between 7s. and 15s. a week in rent, so whereas before 1932 someone on wages of up to 30s. a week would qualify for free milk, after 1932 someone on wages of up to 45s. a week might qualify although only for infants under one year, or women in the last months of pregnancy. (31)



Even so, this remained a substantially worse scale in a much more prosperous locality than either Tottenham or Merthyr Tydfil. In Oxford, the most prosperous area of the four represented here, to obtain free milk in 1931 for a family of five, for one pint for the last three months of pregnancy and for a child of up to one year you needed an income of less than 38s.4d. (no deduction for rent; up to 9d. per day deduction for meals at work allowable). In 1936 this dropped again, to 32s.6d., although rent was now deductible. (32)

The local authorities of Oxford, Oxfordshire, Tottenham and Merthyr all employed their own health visitors. This was all they had in common. In Oxford and Oxfordshire there were fewer services, and a heavy reliance on the charitable voluntary sector. Domiciliary midwifery in the county and infant welfare in the city were almost exclusively carried out by charitable groups 'under licence' from the local authority, although as appears below, power relations were not as simple as this suggests.

As described in Chapter One, Oxford's services were first formed during the period 1905-22, with the help of the Medical Officer of Health, the four influential women from the infant welfare association, and the voluntary hospital. By 1921 Oxford had a sick baby clinic at the voluntary hospital (Radcliffe Infirmary) once a week, an arrangement with the Eye hospital for the free treatment of babies, and an arrangement with the maternity home to keep beds for 'necessitous cases' from Oxford City. There were eight voluntary association infant welfare clinics and four local authority health visitors who worked closely with untrained volunteer health visitors. By 1937 there was a dental clinic, a birth control clinic, there were twelve infant welfare clinics, by this time taken over by the local authority, and two ante-natal/post-natal clinics. By this

time there were ten health visitors, and the connection with untrained visitors is no longer mentioned in reports. In Oxford, free help was hard to come by throughout the period. From 1919, milk orders were available and vitamins for necessitous cases became available too in 1937. However, the vitamins had to be obtained from a special clinic just for cases of hardship, and the arrangement for procuring free milk was tortuous. First, the Medical Officer of Health visited your home, then income details were checked with employers before your card could be obtained, and then you had to pay the milkman first and make a journey to the Town Hall offices with your card to claim the money back. (33) Home helps, obstetric aid, and midwifery were also available through the council, although used less frequently than the population statistics indicate. The clinics, run by doctors and other professionals' wives in the area, sold milk, Virol, material, patterns, and cod liver oil at cost price.

In Oxfordshire in 1920 there were four infant clinics, five health visitors, and four county midwives. In 1937, the Council had hired a voluntary midwifery service, employed general practitioners to provide an ante-natal service, had an arrangement with Oxford's Radcliffe Infirmary and other voluntary hospitals for hospital maternity beds, and had a nominal arrangement with an obstetrician for difficult cases. Free milk, hospital treatment for infants, home helps, confinement costs, and travel costs for treatment were available through the health committee, which only sat once a quarter. Few mothers had services or goods free in Oxfordshire. Tables 6.2 & 3 show the stark differences experienced by mothers in financial and material need in the four areas.

What were the reasons for such differences? Charles Webster has argued that there were economic reasons - Councils in depressed areas had difficulty with their rates, which did



not raise enough money to cope with local need; national grants in these circumstances were hard to obtain, since they had to be matched in the 1920s with local money. (34) In Merthyr Tydfil relatively poor service can be partly attributed to the sheer lack of money within the Council. Merthyr Tydfil was an expensive Council to run even in prosperous times; digging drains and building roads and houses on steep valley sides over coal mines was costly. Attitudes to maternity and child welfare, and to free services, played their part as well in Merthyr, the Labour majority, men and women, wanted more money to be given to families, so they could buy the goods and services they wanted, rather than a variety of means tested narrowly prescribed goods and services. This may partly explain why milk was the one large item on the Council budget, representing a basic and safe addition to the household which could be used at the mothers' discretion. Maternity and child welfare was the patronising domain of the Liberals and Conservatives here, scorned by the Labour working-class wives who were proud of their household and maternal ability. Medical services provided free on an insurance basis to Miners' families, not just mothers and infants, minimised the need for the Council to run out-patient's and screening clinics such as those in Tottenham.

Tottenham's relatively good service and generous scales were connected with the relative prosperity of the Borough, but other factors played an important part. 'The future' had a high profile in this outer London borough; the two successive Medical Officers of Health for Tottenham, Dr Kirkhope and Dr Hogben, both fought hard for a good preventive health service for mothers, infants, and children, but they would not have succeeded without the matching enthusiasm of their Councillors from the Cooperative Labour Party and the Low Church 'Brotherhood', nor would they have succeeded if there had been a strong



charitable presence in the area. (see Chapter Five) The strong local Women's Co-operative Guild faced little opposition in infant clinic teaching; many of the attending mothers were new to the area, starting a fresh life in one of the two London County Council housing estates. Tottenham was an ideal ground for spreading the new scientific methods, and for providing them free where necessary. Oxford and Oxfordshire were both prosperous enough authorities to have provided full services and to have encouraged poorer mothers to claim as many benefits as they needed. The reasons here, as to why the services were so poor and the take up of free service so small, lie in political attitude and power rather than economics. Both Councils were dominated by Conservative and Liberals who also formed the Committees of voluntary organisations in the City and the County. Both saw local authority services as the expensive option to be used only when Voluntary Organisations and Public Assistance failed. Victorian ideals of self-help were raised in discussions about services and scales of eligibility; in 1934 the debate in the Maternal and Child Welfare subcommittee in Oxford as to whether mothers should pay to attend Infant Welfare Clinics so they appreciated them better would have been unthinkable in Tottenham or Merthyr Tydfil(35).

As a final way of emphasising the contrasts in provision and attitude between these four authorities, some statistics for 1937 have been included in Table 6.4. Although much of this Table has had to be estimated from incomplete Minute books, the annual sum spent on maternity and child welfare comes from the annual returns sent to the Ministry of Health. Predictably, Tottenham shows the highest involvement and the largest sum spent on free provision.

Poor Law, Public Assistance, hospital and medical insurance schemes, and charities.

In all the four areas, there were other ways for families to obtain medical services free, through the rapidly spreading insurance schemes and through well established poor law / public assistance channels. Charities provided help of other kinds, such as fares, convalescent treatment, loaned clothes, or cocoa. This context is easy to overlook now, but was thought, certainly in Oxford and Oxfordshire, to provide an adequate safety net for poor families. I will briefly outline these sources of help: Insurance schemes were available to help spread the costs of midwifery, hospital treatment, and motherhood. In all the areas represented here, 2d. a week would secure your family the right to hospital treatment - although in Oxford the insured still had to pay for maternity services. A smaller sum would cover the fee of the district nurse - for illness. If she was called as a midwife, in Oxfordshire, a reduced fee was paid, but she was not free. The £1.10s./£2 maternity benefit paid to those families in work was a welcome sum, but would by no means have covered all costs.

Apart from the Maternity Benefit, National Health Insurance only related to employees, not their families. Insurance schemes covering general practitioner services were available in Merthyr Tydfil through the Union, as related above in Chapter Four, and became available in the Oxford area at 1s. a week in 1937. Tottenham residents could take advantage of the wider network of London hospitals and outpatient facilities through a London Hospitals insurance scheme, remembered as a godsend by one Tottenham resident.(36) Poor law help was always there as a last resort for those who were unable to pay for the institutions, schools, infirmaries, doctors. However, this was, understandably, not a popular option. The following letter, written in Oxford in 1921, shows both how inadequate these 'safety nets' must have seemed, and how they could



become a hindrance rather than a help in times of need.

An employee of mine relates the following: His baby girl, aged 18 months, having sprained her wrist, was treated in the first instance in the Radcliffe Infirmary, but he was warned that she must not be brought there again, as she was suffering from whooping cough; he must call in his panel doctor. The doctor's substitute attended, only to refuse treatment, saying it was a case for the parish doctor. The father is now wondering why he is a subscriber to both the national health insurance and the infirmary.

Yours faithfully Thomas E King

112 Walton St

Oxford. (37) .

### Conclusions

The four local authorities discussed here confirm the existence of material want in contrasting areas of Britain, and show the different profiles given in these areas to scientific motherhood. The labyrinthine procedures to obtain help must have put off many would be applicants. Tottenham mothers on a low income appear to have been better served in every way than their counterparts in Oxfordshire or Merthyr. Advice on modern methods was freely available to mothers of all incomes through clinics, health visitors, magazines, chemists, or the radio. Appetites were whetted, and anxieties raised. Material help, or help in kind, to ensure families on a minimum wage should not go without the prescribed cod liver oil or convalescent treatment, was less forthcoming. The national maternal and child welfare movement, refracted through local attitudes and conditions, provided mothers with very different messages, services and help. Only in Tottenham did poor families not risk getting poorer if they followed the new prescriptions.



Conditions in the 1990s are beginning to echo those of sixty and seventy years ago. A recent report revealed that

one in five parents said they had gone hungry in the last month [December 1990] because they 'did not have enough money' to buy food. Forty-four percent of the parents said they had gone short of food in the last year to ensure that other members of the family had enough. One in ten children under five had gone without food in the last month because of lack of money. (38)

In these circumstances, taking a child to the clinic, a bus ride away, and thus losing half a day's wages and having to pay fares, would deter families who might lose another meal in the search for child rearing advice from the professionals. People are being forced, again, to rely on the generosity of the Round Table, or of charities like Children in Need, as the state services peter out.

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TABLE 6.1

Provision of free milk and meals to infants, expectant mothers and children in 1931 in three South Wales communities

|  | <i>Rhondda</i> | <i>Pontypridd</i> | <i>Merthyr Tydfil</i> |
|--|----------------|-------------------|-----------------------|
| Population   | 141,346        | 42,717            | 71,480                |
| Unemployment   | 40.7%          | 58.3%             | 53.3%                 |
| Nos of free school meals provided                            | 4,065          | 0                 | 1,006                 |
| Amount spent on free milk at clinics                         | £11,061        | £900              | £2,935*               |
| Children found to be subnormal as regards nutritional status | 329            | 301               | 453                   |

\* For expectant mothers and infants under 1 year.

*Note:* Only very rough estimates can be made of the numbers receiving the meals and the milk; 20 children might have received free meals in the Rhondda and 4 in Merthyr, if each child had 5 meals a week for 40 weeks a year. In the Rhondda, 1,000 children and expectant mothers could have received 365 pints of milk costing 3d. per pint. The numbers of children cited here may reflect more about the assiduity of medical officers and the measures they implemented than the real numbers of children who were in need.

*Source:* Save the Children Fund, *Unemployment and the Child* (London 1932).

TABLE 6.2

Scales of Eligibility for 1pt. Free Milk  
From Local Council for Family of Five

|      | Tottenham (a) | Oxfordshire (b) | Merthyr Tydfil (c) |
|------|---------------|-----------------|--------------------|
| 1921 | 37/6          | 32/6            | 35/-               |
| 1931 | 39/-          | 32/6            | 35/-               |
| 1937 | 39/-          | 32/6            | 45/-               |

a. For 1.5 pts. through pregnancy up to 5 years old.

b. For 1pt.

c. For 1pt. in last three months of pregnancy and up to 1 yr. old.

Derived from:

Minutes of Maternal & Child Welfare Committee, Tottenham Borough Council/Metropolitan Borough Council 1919-39

Minutes of the Health Committee, Oxfordshire County Council 1919-39.

Minutes of the Maternal and Child Welfare Committee printed in the Annual Council Minutes Books, County Borough of Merthyr Tydfil, 1919-39.

TABLE 6.3            A comparison of charges for maternity services in Merthyr Tydfil, Tottenham, Oxford County Borough and Oxfordshire in 1937

|                                      | <i>Merthyr Tydfil</i> | <i>Tottenham</i> | <i>Oxford County Borough</i> | <i>Oxfordshire</i> |
|--------------------------------------|-----------------------|------------------|------------------------------|--------------------|
| Midwife                              | 25-30s.               | 42s.             | 35 - 42s.                    | 25s.               |
| Maternity beds (1 week)              | 42s.                  | 63-84s.          | 98s. 7d.                     | 98s. 7d.           |
| Dentist                              | ?                     | 6d.              | ?                            | ?                  |
| Artificial sunlight treatment        | ?                     | 1s.              | None                         | None               |
| Tonsils                              | ?                     | 5s.              | ?                            | 42s.               |
| Convalescence (1 week)               | None                  | 10s.             | None                         | None               |
| Day nursery (1 week)                 | 1s.                   | 6d.              | ?                            | None               |
| Income scales for claiming free milk | 35s.                  | 37s. 6d.*        | 38s. 4d.                     | 30s.               |
| Average weekly income                | 29s.                  | 40 - 80s.        | 40 - 80s.                    | 32 - 37s.          |
| Unemployment                         | 60%                   | 7.8%             | 5%?                          | 5%?                |

'None' means no service was provided.

\* Allowance made for rent, meals, fares, child-care.

Sources: *Minute books* of MCW Sub-committee; MOH A/Rs; H. Llewellyn Smith (ed.) *The New Survey of London Life and Labour*, vol. 3 (London, 1932).

TABLE 6.4

Comparing the budgets for maternity and child welfare as a whole, milk in particular, and the take-up of free milk in Merthyr Tydfil, Tottenham, Oxford County Borough and Oxfordshire in 1937

|  | <i>Merthyr Tydfil</i> | <i>Tottenham</i> | <i>Oxford County Borough</i> | <i>Oxfordshire</i> |
|--|-----------------------|------------------|------------------------------|--------------------|
| Estimated budget for maternity and child welfare               | £7,825                | £15,214          | £4,895                       | £5,500             |
| Money spent on milk and cod liver oil                          | £4,900                | £2,780           | £800*                        | ?                  |
| Estimated individuals in receipt of free milk at any one time† | 1,094                 | 800-900          | 235                          | ?                  |

\* No numbers available for 1937. In 1938, £825 was spent on milk and preparations, and £5,649 16s 3d was spent on maternity and child welfare as a whole. The £800 is therefore a rough estimate based on this.

† All the figures in this column are estimated from monthly reports in the minutes of the maternity and child welfare sub-committees. I have assumed from the evidence that many families received milk for several months.

Sources: *Minutes books* of MCW sub-committees; Treasurers Reports, Council Minutes of all the relative areas.



## CHAPTER SEVEN

### THE MOTHERS THEMSELVES

Institutions, agencies, professionals and volunteers were in loose agreement about the aims of maternity and child welfare, even if their local services reflected the wide variation outlined above. They were there first to combat maternal ignorance amongst the poor with correct scientific up-to-date child rearing information; second, to distribute at reasonable price, or even free to the deserving, the paraphernalia of modern motherhood; and thirdly to refer mothers and children for the correct health medical treatment early enough in pregnancy or infancy to promote good individual future health.

These aims can be found in government papers, local Public Health committees, district nursing associations, Infant Welfare Associations - in short, throughout the written aims of local national independent or state (that is local authority) institutions of the inter-war period. Associations went about achieving the aims differently, giving out more or less free treatment, grants, concentrating on particular aspects of the aims - I've argued reasons for this above - but those loose aims, all focusing on change in maternal practice, were fairly constant. (see above, Chapter One to Six) The normal measure for success of, say, a clinic or a maternity ward was its mortality figures compared to those of local non-attenders. Lara Marks has done comparative work in this area on East London, and Medical Officers of Health at the time often quoted these kinds of figures in their annual reports. This is discussed in Chapter Two above. Changes in the infant mortality rate of the city or district is the normal measure of the success or failure of preventive health campaigns, although, as I have argued, at a local level it is hard to attribute causes of the IMR decline. Another measure of success or failure to explore is the impact on mothers and

children themselves, as they remember it. Did they go to the clinics? Were their perceptions changed? Did they learn to ignore grandmothers' prejudices? Did they seek the prescribed treatment and cures? Or take the convalescent holidays suggested?

The answers are clearly not easy to uncover. Written evidence can reveal how many mothers visited baby shows, reports and photographs in the local newspapers, which mothers were grateful enough to local charities to write in a timely letter to be printed in an annual report, how many mothers gave birth in hospital and how many took advantage of clinic consultation, artificial sunlight or dental treatment.

Even this kind of evidence presents difficulties. The grateful letters arouse suspicion - ploys of this kind are still common enough today to elicit loyalty amongst the volunteers and money from the charitable.

The clinic numbers and the health visitor visits had to be forwarded to the Ministry of Health by local Medical Officers of Health in a bid for the next year's or the next three year's grants. There was every reason to put the best gloss possible on a 'home visit' which might describe a two hour consultation at home or a card through the door.

Similarly a 'clinic attender' may have come once with a small baby to a church hall for a weighing session, stayed ten minutes and never come again, or may have been a regular attender at a well equipped and staffed infant clinic where she received a real cultural immersion. (See Table 2.1 above)

If these are doubtful pieces of evidence, what other evidence is left? How can you tell what individual mothers learnt, and went on to practice from these agencies? The question cannot be ignored; it is one of the real tests, in its own terms, of the maternity and child welfare movement. Did mothers digest the new scientific motherhood taught by



the professionals, in the clinic, through magazines, through advertising, at the general practitioners, through the radio, and directly influence the new generation's health?

A preventive health campaign - Aids, cigarette smoking - can use interviewing surveys to monitor its success. In the case of a campaign held sixty to seventy years ago, interviewing is of far more doubtful value. Many of this age group of mothers, who now would be between eighty and ninety years old, are dead, and amongst those still alive even those without mental ill health have fallible memories, that have often been reconstructed more than once with succeeding generations and very different child rearing fashions from their own. People's own experiences that are sixty or seventy years old cannot be made to replace or stand straight alongside local newspaper articles or other written records of the time. A handful of interviews with men and women in their eighties cannot unveil how many clinic haters, Virol takers, or home confinements there were. However people's experiences do have a place. Where local detailed information exists, as in my own study, mothers memories provide invaluable illumination from the ground. They have confirmed points of view suggested by the written evidence, or in some cases have suggested a completely different viewpoint about services and professionals.

People's memories can help particularly over details, since this is what seems to survive most clearly - what children ate, how they were dressed, how the days were spent. This serves to give some impression, in a few cases at least, of what impact the avalanche of advice had on its audience. People also remember whose advice they liked to take, and what part their mother or neighbour, the nurse, midwife, general practitioner, 'volunteer' took in their own practice of motherhood.



A handful of mothers with particularly vivid memories are quoted below. All the interviews took place between 1985-1990, in people's own homes; one of these homes was a local authority residential home in Thame, Oxfordshire. (1)

To begin with an Oxford informant. Mrs Eldred was born in Oxford, and apart from a short period away in service lived in Oxford all her life in a working-class district of town. She was married to a milkman with a wage of less than 30s. a week, so housekeeping was a struggle. This eased slightly when the children were older, and she took a job as a daily mother's help. She had decided views on childcare, mostly in accord with the new scientific methods favoured by the experts. Days were patterned by routine. Mrs Eldreds meals were at 1 o'clock and 5 o'clock. There was always a walk in the park before tea for the children.

When Yvonne [born 1938] was a baby I always took them all round Christchurch Meadow ... every day we went there ... then I used to bring them home and give them their tea and put them to bed- that was their lot at 6 o'clock ... I think really and truly they're tired by then and you're tired with your own walk and all.

She followed the four-hourly breast feeding routine favoured by followers of Truby King at the time

I fed him at 6 o'clock in the morning then we used to get them up and bath them then the two o'clock then

6 o'clock at night But she was more lenient than Truby King followers about the night time - they insisted in the manuals that a baby should not be picked up or fed between 10 p.m. and 6 a.m.:-

my kids were always hungry ... they used to have a meal in the night...well I mean you'd got it with you hadn't you, you hadn't got to warm it up.

Mrs Eldred often mentioned things 'they' thought were right.

In those days it was a terrible thing if you didn't want to feed your children because they reckoned it was much better, a breast fed baby; but they used to

give us Epsom Salts to dry up the milk when they were on to something solid, just before the twelvemonth. I fed both of mine about eleven months.

When her first baby was born in 1936 following two days in labour she was advised by the doctor to 'lay the baby on a pillow beside you in the bed - the warmth of your body will do him good'. She was perplexed by this advice knowing that 'they didn't hold with the old fashioned method of having the baby in bed with you.' and she was not satisfied until she found out from her husband, who was in the room too by that time, that the doctor had not expected the baby to live. That, in her mind, justified the doctor 'breaking the rules'. Mrs Eldred had booked the midwife, who had had to call in the doctor during labour.

She remembered that

Recipes were given by the doctor..at six months they used to give a paper, how to boil a leg bone for so many hours, then let it stand and take the fat off and then boil it next day and put the vegetables in it.

Despite following all this advice, Mrs Eldred was against the clinics. After a few visits she and her friend decided to stop taking their babies, and began to use the neighbourhood chemist instead.

We used to go to the clinic and have them weighed but I never kept to it regularly. I didn't like it really ... I didn't like undressing him in front of all the other people ... one baby wetted on the seat ... it got that I didn't go and I used to bring him down to the Abingdon Road chemist and he used to weigh him there ... he said weigh his clothes when you undress him and take that much off.

She was undeterred by a visit from a clinic worker whom she found very patronising:

We had the lady come and see us [probably one of the volunteer health visitors who by the later thirties had become volunteers at the clinics] one

of the people that was to do with the weighing in and all that with the babies and she was quite cross because I wouldn't keep coming. I said I'm not going ... to me it's not clean ... I reckon my baby would pick up more in a place like that than keeping him to myself.

So where did Mrs Eldred learn her baby care? Not from her mother, who held a fairly peripheral role. She was over sixty when the first of Mrs Eldred's babies was born,

My mother was very good ... she never interfered but said if she thought a thing was good or bad ... she said at the birth well I can't come and look after you but she said I'll see you have some gruel made with fine oatmeal and milk ... I had no end of that...they reckon that's what made the milk.'

That seems to have been the end of her mother's part in the story. People of importance after that were her neighbour, the chemist, magazine articles that passed from hand to hand, the doctor at the ante-natal clinic, Dr Mary Fisher, and the doctor who was called in by the midwife who had at the time of the delivery offered free consultations any time she wanted to drop in because she reminded him of a woman he had once known.

The barriers between her and the service providers include a feeling of being patronised, a fear of germs at the clinic (somewhat ironic) and the stumbling block of only half understanding explanations at the ante-natal clinic, and not having enough money to pay for repeat prescriptions. (see above, Chapter Three)

Mrs Hawkes, who has lived all her life in Thame, a small Oxfordshire town, had children slightly earlier than Mrs Eldred, in 1931 and 1934. She only had two - when asked why



her family was this size she said she was lucky because she had a kind husband who 'studied her'. Her mother lived on the same street and played a large part in her children's upbringing. Her husband was a mechanic bringing in 50s. a week - you had to 'study your pence' in those days, she remembers. For her, the clinic, the doctor, her mother, all played an important part in how she brought up the children. For the birth, she had

Mrs Beasley, not the district nurse ... she wasn't trained ... she was a friend of my mothers'... she came round and delivered the babies ... she was a dear ... she held your hand and rubbed your back ... the doctor came when the time was due

This memory suggests that maternity nurses or indeed skilled neighbours in the handywoman tradition may have continued to play an active part in pregnancy and childbirth long after professionals assumed they had been superceded by professionally trained personnel. An article in the Medical Officer in 1926 titled 'The Survival of the Handy Woman' describes this practice, 'It seems that a very large number of people prefer a handy woman to a midwife when they have engaged a doctor to attend' .(4)

Mrs Beasley stayed in bed ten days after the birth. She remembers wanting to get up but her mother would not let her, and she was in some awe of her mother: 'you had to rely on your mother in those days ... I was frightened to death to tell her ... she turned on me terrible when I fell for Dorothy.

Her mother helped with preparation before the birth, sewing all the flannel nightdresses, the body belt, and the nappies.

You got them as your time went on, all this tackle, you see you just bought your bit of stuff in the market and made them ... all by hand ... I didn't have a machine in those days.

She remembers the expense of it. 'We had to save up when we knew we were having a baby' and her husband made the cot 'a nice high thing they slept in beside the bed'. The doctor's fees were high - between four and five pounds - for the second child, who was delivered by forceps. Rather like Mrs Eldred, Mrs Hawkes only half understood the doctor's explanation and ended blaming herself: 'He was tucked up round the corner somewhere I think I fell off - slipped off the settee when I was pregnant ... I expect that done it ... while I was expecting'. Mrs Hawkes didn't feed at set times 'just when they were a bit stroppety'. Her regime seems to have been more relaxed than Mrs Eldred's. 'They often slept in the pram in the garden- near the window so I could hear them crying; mother thought it was a good thing'. Throughout childhood, the daughter went backwards and forwards from her mother's to her grandmother's house. 'As soon as she could get on her feet she was down at her grannies ... lived practically down there with her ... if she was missing I knew where she was'. Yet despite the reliance on her mother, Mrs Hawkes was a regular visitor at the clinic.

Yes we used to have the clinic here somewhere down at the church hall it was. They used to weigh them, undress them to see they were alright ... I suppose... check them and answer questions if you were a bit worried about anything ... plenty of mothers there you met and discussed your children with and see yours is a bit better than theirs, yes it was quite nice going down there ... you could buy anything cod liver oil and malt they used to love that

You can almost feel the tension between the different methods of child rearing - her mother's and the clinic's - in her account. Mother was criticised for being too indulgent.

Granny would let her do things which I'd never let her do ... stand up on a chair at the sink ... she



got away with all these things ... she'd come back with her vest all smeared with camphorated oil - clogged up - with her granny's dirty hands.

She respected and relied on the doctor who always came when they were small: 'He was lovely with the children ... came out any time ... middle of the night or anything ... he operated on my daughter for appendicitis.' But of course they had to pay for him: 'We saved up ... his bill was three or four pounds.' They paid 2d. a week per adult for the hospital fund, and it's a measure of how tight the budget was that: 'when the woman came round on the daughters tenth birthday and demanded an extra 1d a week from the family I was so upset.'

All the ten informants from Thame remembered the clinic; all weaned about 6 months onto beef tea and could remember the recipe; all remembered the kindly doctor, and all the others besides Mrs Hawkes used the district nurse-midwife, Nurse Cook, who delivered 1000 babies in twenty-five years in Thame and was a familiar rather strict figure on her bicycle around Thame and the surrounding villages at the time. This part of rural Oxfordshire had a strong voluntary ethos. The chairman of the County Council, Mr Ashurst, himself chair of many voluntary associations as well (see Chapter 5 above) lived just outside the town in a large establishment with his daughter, a committee member of the Oxfordshire Nursing federation. The clinic was run by the local doctor's wife and many volunteers.

Most mothers in Thame were close to their own mothers. One said her mother had stayed with her and held her hand throughout labour, and when I asked one if her mother babysat, she said she would rather go out with her mother than anyone. Another: 'Oh my mother said you only feed up to eight or nine months so I did ... they never had it after'. Here the clinic prescriptions were tempered by grandmother.



Stories from Tottenham and Merthyr are different again. In Tottenham, a visit to the clinic for any kind of baby equipment or advice was as familiar as Mrs Eldred's visits to the chemist - you dropped in at any time. One mother was rather cross to be turned away once because the clinic doctor thought her child was sick, and might infect the other babies.(5) Tottenham mothers took for granted the range of facilities, from the gynaecological clinics to the minor ailments ones. They were part of a well-ordered civic life that was remembered in contrast to early days in the cramped East End, before they were lucky enough to have a flat in Tottenham. Clinics, supervised play in the parks, Woodcraft Folk, swimming, convalescent holidays, festival weeks - these were memories of being part of a community newly and energetically formed.(6)

In Merthyr informants remembered the midwives - there was a wonderful story about the midwife who was so drunk she climbed onto the bed before the woman in labour could get there, and refused to rise - but there was none of the emphasis on routine, fresh air, special diet, or special feeding patterns. Mothers and sisters brought up siblings and cousins without the overt advice of experts. Those that I asked were not sure about the health visitor. They remembered the clinic, but expressly not for child rearing advice - instead it was thought of as the place where on presenting the husband's unemployment card and the new born baby, you were automatically granted a pint of milk free until a child's first birthday. The predominant memory was of hunger and want, and the warmth and help of families.

Taken with the written evidence, these memories indicate many of the difficulties of the kind of public health campaign that maternity and child welfare represents. Aimed at providing the safer confinements, and scientific childrearing methods, that would promote child and maternal

health, the campaign came up against individual beliefs, family structures, local structures and interpretations. Respect and sensitivity for the working class family by professional or volunteer created loyalty and converts, but cost, tradition, more pressing preoccupations, lack of knowledge of what was on offer and the lack of medical understanding, could still be barriers to change.

### Conclusions

The aim of the national maternity and child welfare movement was to effect change in individual patterns of family care in the interests of the succeeding generation, who were to be healthier, better citizens and live longer than their parents.

As with any such movement, achievement of these aims relied on the dynamic relationship between the advice givers and the families advised. This is the reason for concentration on a series of local studies rather than on policy at the national level. It emerges that areas with enthusiastic health visitors, or mothers eager for change, show more success than those entrenched in traditional patterns. The research findings presented above demonstrate a variety of response. In addition they demonstrate that because of local circumstance, a national movement such as this could be adopted or derided to fit local needs to such an extent that although the same rhetoric might be used, the aims and actions of those promoting the changes split the national movement into a series of separate local movements with divergent aims. Although formally under state supervision, 'state services' was hardly a justified title for the services in the four areas outlined here. They were local services, largely conceived as a balanced mix of voluntary and statutory provision, that drew on a state grant system and was more or less regulated by state inspection from the Ministry of Health. Moreover, our notion, grounded in years of a British Welfare State, that State services are meant to



be free, at least at the point of delivery, is shown to be erroneous for the inter-war period. The Ministry urged throughout the period that schemes should be self-supporting where possible, through charges, the use of volunteers, and the provision of minimum material help. Where authorities like Tottenham pushed for maximum grants the Ministry rejected their applications wherever possible, and where authorities provided meagre services the Ministry was slow to promote services that would entail a larger national grant. Under the Midwives Act guidance, Authorities were forced to explore the cheaper voluntary alternatives before turning to the option of employing municipal midwives.

The state service so enthusiastically recommended by George Newman in 1939 was itself a licensing, inspecting, grant giving mechanism that encouraged only the minimum to be available free of charge locally. The main body of service encouraged by the Ministry in local authorities was designed to alert mothers to medical services they would have to pay for, and material goods they would have to pay for, which may well have had the unfortunate affect of making poor families on the edge of malnutrition even poorer and more malnourished as they tried to comply with the prescriptions of the new motherhood. There were hard won exceptions to this pattern; Tottenham gave young families in need, in a carefully means tested environment, as many medical services and material goods as the Ministry allowed, and Merthyr Tydfil did what it could in an economically appalling situation. But the pattern was clear. It is perhaps as well that many of the mothers above took only what they wanted from the clinics, remaining oblivious to the strong messages that might have added to the burden of anxiety and poverty at this time when most working-class families had of necessity to 'study their pence'.



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## Appendix 2

### Key Maternal and Child Welfare Legislation.

Source- Social Services in Oxford II, Appendix 1, p 473 W. Robertson and C. Porter, Sanitary Law and Practice. A Handbook on Public Health, London, 1931.

### Maternity and Child Welfare Act, 1918

Section one of the Act empowered local authorities to make arrangements for attending to the health and welfare of expectant and nursing mothers, and infants under five not attending school.

Section two directed local authorities to establish a Maternity and Child Welfare Committee, either by extending the powers of an existing Committee, or by setting up a subcommittee of an existing committee, but all matters relating to the Act in question or the Notification of Births Act stood referred to it. One third of this committee might be co-opted i.e. not Councillors; two members had to be women.

'The principal powers and duties of maternity and child welfare committees were stated by the Local Government Board in 1918 to be

- 1) The maintenance of a sufficient staff of health visitors to supervise expectant and nursing mothers and infants and children under five years of age, to make special visits to children suffering from infectious diseases, and to assist at infant welfare centres.
- 2) The activities of maternity and child welfare centres to include medical supervision and advice for expectant and nursing mothers and for children under five years of age, the treatment of minor ailments in pre-school children, and the education of parents in the general hygiene of maternity and childhood.
- 3) The provision of food and milk to expectant and nursing mothers and to infants and young children needing extra nourishment and in poor financial circumstances.
- 4) An adequate service of trained midwives and adequate inspection of their work.
- 5) The payment of doctors when called in by certified midwives to mother or child in case of necessity.
- 6) A service of nurses for illnesses of pregnancy or confinement, puerperal fever, ophthalmia neonatorum, measles, whooping cough, poliomyelitis, and epidemic diarrhoea in young children.
- 7) Provision of hospital accommodation for acute illnesses connected with pregnancy, confinement, and infancy.
- 8) The provision of maternity home accommodation and of

homes for infants suffering from malnutrition or other conditions which are not usually admitted to hospitals.

9) The provision of convalescent homes for women after confinement and for infants and young children, and of rest homes for expectant mothers if need arises.

10) The provision of accommodation in homes or otherwise for widowed, deserted, or unmarried mothers.

11) The provision of day nurseries, creches, or other means of looking after the children of women who have to go out to work.

12) The provision of home helps for taking care of the home during the period of the mother's confinement.'

These powers and duties to attract a 50% grant if given approval by the Ministry of Health, payable in arrears annually. After 1929 this changed, and Authorities were given a lump sum calculated on population figures, economic factors, and previous expenditure. Before 1929 Voluntary bodies could apply in their own right for 50% grants, but after 1929 their needs had to be met through the lump sum given to Local Authorities.

Richer and more committed authorities, such as Tottenham, applied for many grants before 1929, which meant that after 1929 the government continued to support a large number of existing services. In Merthyr or Oxfordshire, where in the former for want of money and the latter for lack of commitment there was little grant take up before 1929, services remained sparse after 1929.

Other significant Acts include:

Midwives Act, 1902

Midwives Act, 1918 (amending legislation)

Notification of Births (Extension) Act, 1915

Midwives and Maternity Homes Act, 1926

Nursing Homes Registration Act, 1927

Midwives Act, 1936.